

**‘DESIGNER VAGINAS’: THE REPRESENTATION OF FEMALE GENITALS  
ON CANADIAN COSMETIC SURGEONS’ WEBSITES**

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## **Abstract**

This thesis critically examines the online marketing tactics of 10 (English language) Canadian cosmetic surgery clinics' websites that offer Female Genital Cosmetic Surgery (FGCS), specifically, labiaplasty (labial reduction) and vaginoplasty (vaginal tightening). Drawing on a qualitative Multimodal Critical Discourse Analysis (MCDA) and a feminist-informed social constructionist framework (Lazar, 2007), I examine how FGCS discourses reiterate and reinforce heteronormative sexual scripts for women, and impose restrictive models of femininity through the pathologization of genital diversity and the appropriation of postfeminist and neoliberal discourses of individual choice and empowerment. I explore feminist analyses of the links between FGCS and contemporary Western women's postfeminist subjectivity, and the reconfiguration of women's sexual agency, to better understand what these contemporary shifts may mean for women's sexual anxiety and expression. My analysis highlights several discourses that organize the online marketing material of Canadian FGCS websites, including: the pathologization of genital diversity; restrictive models of femininity; heteronormative sexual scripts; neoliberal and post-feminist rhetorics of individual choice and empowerment; and psychological and sexual transformation. Overall, these discourses undermine acceptance of women's genital diversity, legitimize the FGCS industry and frame FGCS as the only viable solution to alleviate women's genital and sexual distress despite the lack of evidence regarding the long-term benefits and risks of these procedures, and the recommendations against FGCS by professional medical organizations.

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## Chapter 1: Introduction

### Research Premise and General Objectives

The best thing a cunt can be is small and unobtrusive: the anxiety about the bigness of the penis is only equaled by anxiety about the smallness of the cunt. No woman wants to find out that she has a twat like a horse-collar (Greer, 1971: 39 – quoted in Braun & Wilkinson, 2001: 264).

Germaine Greer's candid pronouncement that women experience genital distress comparable to that of men continues to be salient some forty years later. Contemporary Western women seem increasingly concerned about the symmetry of their labia minor and the tightness of their vaginal canal. Consequently, elective aesthetic surgery on female<sup>1</sup> genitalia, known as Female Genital Cosmetic Surgery (FGCS),<sup>2</sup> has become a “booming business” (Liao & Creighton, 2007: 1090).

My thesis critically examines the Canadian online marketing tactics of cosmetic surgeons that have been linked to the growing demand for FGCS (Schick et al., 2010). FGCS<sup>3</sup> refers to a range of cosmetic procedures performed on internal and external female genitalia with the intention of altering a woman's genital appearance to fit a narrow aesthetic ideal, while simultaneously purporting to improve sexual functioning and/or enhance sexual pleasure (Braun, 2010; Goodman, 2009; Goodman et al., 2010; Malone, 2013; McDougall, 2013; Rodrigues, 2012; Schick et al., 2010). I employ a

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<sup>1</sup> Given the subject matter of my thesis, the terms ‘female(s)’, ‘woman’, and ‘women’ will signify cisgender and cissexual women (Rodrigues, 2012: 791).

<sup>2</sup> Also referred to as cosmetic genitoplasty (Liao & Creighton, 2007); vulvovaginal esthetic surgery (Goodman, 2009); and in the media, marketing, and popular nomenclature as ‘Designer Vaginas’ (Braun & Tiefer, 2010; Malone, 2013; Rodrigues, 2012; Schick et al., 2010). FGCS has no clearly accepted or consistent definitions (SOGC, 2013: e3). FGCS procedures are often referred to by non-medical names, which should be recognized as marketing terminology only (SOGC, 2013: e3).

<sup>3</sup> FGCS refers to a distinct group of procedures performed on the female genitalia and does not include: gender reassignment surgeries; genital surgeries performed on intersexed individuals; and/or ‘traditional’ female genital cutting (Braun, 2005a: 407; Braun, 2009a: 133; Braun, 2009b: 234).

feminist multimodal discourse analysis to review and critically assess 10 Canadian cosmetic surgery clinics' websites that offer a range of FGCS procedures. I focus specifically on marketing for labiaplasty (labial reduction) and vaginoplasty (vaginal tightening) – the two most common procedures (Braun & Tiefer, 2010). My aim is to assess the discursive and visual strategies used to promote FGCS, despite the lack of evidence regarding the long-term benefits and risks of these procedures, and the public outcry from feminist activists and professional medical organizations (American College of Obstetricians and Gynecologists (ACOG), 2007; Braun & Tiefer, 2010; Rodrigues, 2012; Royal Australian and New Zealand College of Obstetricians and Gynaecologists, 2007; Royal College of Obstetricians and Gynaecologists, 2009, 2013; Society of Obstetricians and Gynaecologists of Canada (SOGC), 2013; Tiefer, 2008).

The purpose of my research is to explore the relationship between contemporary Western beauty ideals regarding women's genitals and the discursive construction of women's bodies and sexuality in the advertising of Canadian cosmetic surgery clinics' websites. I examine how FGCS discourses reiterate and reinforce heteronormative sexual scripts for women, and impose restrictive models of femininity (Gillespie, 1996: 69) through the pathologization of genital diversity (Rodrigues, 2012; Tiefer, 2008; Weil Davis, 2002) and the appropriation of post-feminist and neoliberal discourses of individual choice and empowerment (Gill, 2008a, 2008b). Drawing on feminist analyses of the links between FGCS and contemporary Western women's postfeminist subjectivity, and the reconfiguration of women's sexual agency, I explore what these contemporary shifts may mean for women's sexual anxiety and expression (Attwood, 2006; Gill, 2008a, 2008b). I locate my analysis within a broader critical analysis of

women's embodiment in the 21<sup>st</sup> century's 'perfectionist body project' and makeover culture (Lazar, 2011; Tiefer, 2008: 467), contemporary and historical representations of women's genitalia and "pudendal disgust"<sup>4</sup> (Lazar, 2011: 37; Tiefer, 2008: 475), the sexualization of culture (Attwood, 2006; Gill, 2008b; Gill & Donaghue, 2013; Levy, 2005; McNair, 2002; McRobbie, 2004), and the rise of sexuopharmaceuticals and the "Viagra phenomenon" (Tiefer, 2006: 286).

The marketing of FGCS procedures, along with the industry's commercial imperative (Tiefer, 2008), is problematic and controversial, especially when examined through a bioethical lens. Several surgeons have suggested that the industry-wide practice of aggressive marketing of FGCS has "increased demand for these procedures and enabled them to flourish despite the paucity of evidence" regarding their impact (Braun, 2010: 1401; Braun, 2009a; Renganathan et al., 2009). Rachel N. Pauls (2007) claims that surgeons' unique and secretive practice of patenting FGCS procedures to protect their 'intellectual property rights' fuels criticisms that surgeons are primarily motivated by financial gain, which triggers concerns about these procedures' safety and efficacy. In Adam Ostenzenski's (2011: 617) extensive review of the existing medical literature on cosmetic gynecological practices, he also questions "the ethicalness of creating and relying on medical terminology, trademarks, and business models which attempt to control the dissemination of clinical-scientific knowledge in an effort to maintain copy and patent rights." Hennink-Kaminski and Reichert's (2011: 53) research also supports the claim that cosmetic surgeons tend to market their procedures "by employing strategies and tactics more-typically associated with branded consumer products and

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<sup>4</sup> Term offered by Leonore Tiefer (2008) to signify the wide range of historical and contemporary sociocultural contexts and manifestations of vaginal hatred, contempt, abhorrence, revulsion, etc.



services” a set of practices that has been publicly denounced as unethical (ACOG, 2007; Braun & Tiefer, 2010; SOGC, 2013). Provider websites offer a distinct perspective into the public and medical discourses surrounding FGCS, most markedly because of their purpose – the ‘selling’ of these non-medically indicated surgical procedures to potential clients (Braun, 2009a). Hence, surgeons’ websites are an important area for critical examination by feminist scholars in the field of critical cosmetic surgery studies.

### **SOGC Statement & International Medical Associations**

In December 2013, the Society of Obstetricians and Gynaecologists of Canada (SOGC) released a policy statement that strongly advised against FGCS procedures in Canada. Their objective was to provide Canadian gynaecologists with evidence-based guidance and direction for FGCS. This policy statement responded to the proliferation of non-medically indicated vaginal and vulvar cosmetic procedures in Canada. In a *National Post* interview, Dr. Jennifer Blake, CEO of SOGC, spoke candidly of what troubles her most about these procedures, namely that “women are being made to feel insecure and unhappy about a perfectly normal, healthy part of their body and will submit themselves to costly surgery when we just don’t know what the long-term impact is going to be” (Kirkey, 2014). The policy statement outlined six recommendations and a rationale for the SOGC’s position based on their assessment of the available evidence concerning procedure efficacy and safety (SOGC, 2013: e5). The SOGC (2013: e4) states in their fourth recommendation that the “advertising of female genital cosmetic surgical procedures should be *avoided*” (emphasis added). The SOGC (2013: e4) adds that surgeons who choose to provide FGCS procedures “should not promote these surgeries for the enhancement of sexual function” as there is minimal evidence – mostly anecdotal,

non-scientific and short term – to support the claim that FGCS procedures result in improved sexual satisfaction and/or self-image for patients. The SOGC (2013: e4) considers FGCS advertising by surgeons and clinics unethical in any medium (print, Internet, etc.), because it may engender a false sense of need for surgical alteration in women based on information that can be misleading and, therefore, susceptible to misinterpretation. Further, the SOGC (2013: e4) highlights the conflict of interest at play where surgeons provide these procedures; because there is a lack of evidence to support their claims for the benefits of these surgeries, serious questions arise about the ethics of surgeon's profiting from offering FGCS in the private medical sector.

Lloyd et al. (2005) also assert that there is no convincing evidence to support the claim that FGCS procedures enhance either the psychological or relationship wellbeing of women. They recommend non-surgical methods, which have been successfully proven to alleviate both psychological and/or relationship distress in the general population (Lloyd et al., 2005: 645). Similarly, Dr. Thomas G. Stovall, a past president of the Society of Gynecologic Surgeons (American Association), affirms that there currently exists no scientific evidence to support “the claim that women experience enhanced sensation during intercourse” after undergoing FGCS procedures, to the contrary, he claims that women are more likely to feel pain and discomfort upon penile penetration (quoted in McNarama, 2006: 10). The United Kingdom's Royal College of Obstetricians and Gynaecologists (RCOG, 2009) echoes these cautionary sentiments when they warn that “there is the potential for a woman to be harmed by these procedures” and that there is “very little scientific evidence regarding their benefits” (quoted in Malone, 2013: 12). The Royal Australian and New Zealand College of Obstetricians and Gynaecologists’

(RANZCOG, 2008) statement on *Vaginal ‘Rejuvenation’ and Cosmetic Vaginal Procedures* is consistent with the SOGC’s position; they staunchly discourage “the performance of any surgical procedure that lacks current peer reviewed scientific evidence”<sup>5</sup> (quoted in Malone, 2013: 12). Finally, the American College of Obstetricians and Gynaecologists (ACOG, 2007) released a statement addressing FGCS, which strongly cautions that these “procedures are not medically indicated, and the safety and effectiveness...have not been documented” and that no adequate published medical findings exist on the long-term satisfaction, safety and complication rates surrounding these procedures (quoted in Braun, 2012: 43; Chalker, 2009; Liao et al., 2012: 1). The ACOG’s (2007) statement goes on to highlight the ethical issues surrounding the marketing and national franchising of FGCS procedures, and called the industry’s current secretive business practices – most notably the withholding of scientific knowledge – troubling for medicine (Tiefer, 2008: 470).

I draw on this research to highlight the significant contradiction between the continuing demand for these procedures offered by numerous physicians across Canada despite the consistent and clear warnings against the practice of FGCS from well-respected international obstetric and gynaecological associations. As there is no research on the marketing of FGCS in Canada, I hope that my investigation might articulate a timely and relevant contribution to the existing academic literature on this topic.

### **Combating a Taboo**

Virginia Braun (1999) eloquently captures the struggles of researching the ‘taboo’ topic of vaginas in her article *Breaking a Taboo? Talking (and Laughing) about the Vagina*. She discusses the reactions she routinely received from peers and colleagues

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<sup>5</sup> With the exception of only an appropriately constructed clinical trial.

when she would disclose that her research topic concerned female genitalia. Braun (1999: 267) recalls the tone of “patronising jocularity about the academic absurdity of such a topic.” This ridicule and delegitimation of ‘troublesome’ or ‘risqué’ feminist research topics, which encompass research on sex and sexology more broadly, can turn hostile, and may suppress important and constructive research from being conducted. More broadly, the respective safety or hostility of one’s research milieu has genuine repercussions for the practice and dissemination of feminist research (Braun, 1999: 371). When I reflect on my own research on FGCS, I have often encountered similar reactions from my family, peers, students, academics, and even some SJES professors in my MA program. During the course work phase of my program, one professor plainly stated his opinion - in front of my classmates - that my topic was *not* a social justice issue, because women *choose* to have these procedures. I was stunned by his inability to critically contextualize contemporary notions of ‘choice’ in our neoliberal, patriarchal, consumerist, and capitalist society. He and many others simply equate justice with the liberal notion of ‘choice’ thus precluding further critical exploration at the expense of analyzing the overdetermined context in which ‘choices’ are constrained. After this refusal to connect my thesis with social justice scholarship, I realized that this area of feminist scholarship and activism is a relatively new analytic. I would require determination and persistence to convince other academics - let alone the general public - of my topic’s intrinsic merit and value.

This incident has prompted me to critically assess the rhetorics of ‘choice’ in relationship to FGCS, and to highlight the gendered and social justice implications of current trends to medicalize and market women’s body projects. Other responses to my

project have implied that research on FGCS was frivolous and non-rigorous, an assessment that presupposes that more ‘urgent’ matters affect women in the West. I want to combat the assumption that women undergoing FGCS procedures are simply vain, vapid, and insecure. To do so, I contextualize my research by emphasizing the very *real* and negative consequences of genital anxiety, and their results for women’s wellbeing, self-esteem, and sex lives. However, in recognizing that women are anxious about their genitalia, I do not want to be interpreted as ‘endorsing’ or ‘condoning’ either the practice of FGCS or the sociocultural norms that contribute to women’s genital insecurity and hatred (Davis, 2003: 13-14). Unlike feminist scholar Kathy Davis (1995; 2003), I do not situate women’s requests for cosmetic surgery (or more specifically FGCS) as “a reflection of [some] underlying truth” or as emanating from an “authentic inner desire” (Braun, 2005b: 347). Rather, I emphasize the sociocultural norms that structure women’s dissatisfaction with their genitalia (Parker, 2010). Further, I heed Braun’s (2011: 532) warning that scholars need to remain vigilant against “inadvertently essentialising women’s distress about their genitalia” and the assumption “that this distress is difficult or impossible to shift without surgery.” Instead, I focus on the sociocultural origins of female genital distress and anxiety, in the hope that my research will contribute to feminist efforts to combat contemporary ‘pudendal disgust’ and to offset demand for these procedures (Braun, 2011; Tiefer, 2008: 475).

I concede that unsettling contemporary feminine beauty and genital ideals is a difficult task; numerous feminist scholars have already critiqued many aspects of women’s bodily dissatisfaction and the societal importance and pressures placed on women’s physical attractiveness (see for example, Bordo, 1997; Sullivan, 2001; Wolf,

1990). Moran and Lee (2013: 16) note the privileged status appearance has over other aspects of women's identity, and the ways these discourses contribute to the contemporary acceptance and desirability of cosmetic surgery (Raisborough, 2007). Braun (2005b) has also acknowledged the seductive and persuasive nature of cosmetic surgery discourses. She (2005b: 349) has gone as far as to admit that she herself has experienced how these prevailing discourses "disrupt [her] (relatively) contented embodiment" and make her feel "less comfortable with [her own] body." Similarly to Braun's (2005b) experience, and to my partner's frustration, I too have found myself to be increasingly preoccupied and concerned with minor so-called bodily 'defects' or 'flaws' throughout the research and writing of my thesis. Other feminist scholars have also observed this heightened sense of bodily self-scrutiny, which developed in relation to their own work on cosmetic surgery. In Virginia L. Blum's (2003: 47, 48) novel *Flesh Wounds: The Culture of Cosmetic Surgery*, she divulged that her "own body [had] been at risk since [she] began [her] project" because these discourses are "so hard to resist." Although I have never experienced any distress or anxiety about my own genitalia, I am nonetheless a white cisgendered woman who lives in a culture where female (and sexual) attractiveness are paramount. As a result I have felt insecure about other aspects of my body, in particular the 'smallness' of my breasts, the asymmetry of certain facial features, and my fluctuating weight. By reflexively acknowledging my own bodily insecurities, I hope to better understand the anxieties that push some women to relieve their feelings of inadequacy and distress by 'correcting' their perceived 'flaws' through cosmetic surgery, including FGCS.

Outside the supportive environment of my supervisory committee, I believe the lack of recognition of research on this topic is directly linked to the continued salience of discourses that reinscribe the “‘unmentionable’ nature of the vagina” (Braun, 1999: 370). I hope my analysis will help disrupt public unease with women’s genitalia by deconstructing the division between ‘public’ and ‘private’ spheres. Making the personal political has been a well-known feminist strategy (Braun, 1999), as it situates women’s personal, embodied issues in the realm of both academe and public politics. In particular, second wave feminists facilitated the critical discussion of “so-called private issues into public discourse” (Braun, 1999: 367). This feminist strategy is noteworthy because the simple act of labeling a topic ‘private’ can divert our critical lens away from contemporary manifestations and discourses of power that sustain disparity and discrimination (Beveridge & Mullally, 1995 cited in Braun, 1999: 367). Therefore, it is crucial that feminist research and activism continues to subvert the status quo by making the private both public and political through consciousness-raising projects (Braun, 1999: 369).

Nevertheless I have found that bringing the ‘private’ into the ‘public’ realm of awareness is difficult, especially as my research concerns the representation and regulation of women’s vulvas and vaginas, because public discussion of these issues violates our social codes of ‘morality,’ ‘respectability,’ and ‘politeness.’ The vagina is not easily spoken of in academic, social, educational, political and even medical contexts and institutions (Braun, 1999: 370). However, as long as the vagina remains ‘private’ and ‘hidden,’ Braun (1999: 370) cautions that it will also “remain conceptually ‘absent’” from the lives of women and feminist theory. Consequently, women need to be

encouraged and allowed to ‘own’ and experience their genitalia “as part of their embodied identities” (Braun, 1999: 370), because the vagina and vulva are the focal point of numerous bodily processes, ailments, and interactions such as menstruation, masturbation, coitus, orgasm/sexual pleasure, pregnancy, childbirth, sexually transmitted infections, yeast infections, vaginitis, cancer, and menopause. Women’s sexual anatomy is an important component of women’s overall health and wellbeing, and therefore it is critical to foster an awareness and understanding of, and comfort with, their vaginas (Braun, 1999: 370). My research aims to confront derogatory and harmful representations of women’s genitalia and sexual pleasure by contextualizing their historical and patriarchal origins (Braun, 1999: 370). I offer positive feminist alternatives that reframe and reconceptualize the vagina and vulva by exposing “the shame, secrecy and lack of awareness that often accompany both the having of, and speaking of, the ‘vagina’” (Braun, 1999: 370).

In addition to combating the ‘taboo’ about research on representations of female genitalia, I have faced another set of assumptions about the motivations for my research. Similar to Braun’s (1999: 368) experiences, people tend to wonder “about the potential skeletons in [my] own closet;” or more specifically, the ‘size’ and ‘appearance’ of my labia. I have often faced the assumption that my motivation for researching this topic is because I myself have ‘large protruding inner labia.’ Why else would I be advocating for better sex education on female genital diversity and acceptance? Braun (1999: 368) succinctly sums up this recurring experience of the questionable and assumptive positionality of the researcher in relation to their ‘taboo’ topic or area of research when she notes that “the writer risks association with the unseemly roles of voyeur and



exhibitionist” simply “because of the charged nature of the topic.” Therefore, it is not surprising that throughout my research process I have become closely associated with and marked by my topic of research, a process which I believe is meant to act as a way of silencing women from speaking out about such ‘charged’ topics, especially those concerning women’s sexuality and reproductive health.

## **Chapter 2 – Contextual Overview of FGCS**

### **Introduction**

This chapter provides a contextual overview of FGCS that describes the medical practice of FGCS, its terminology, the role of the media in stimulating demand, as well as the various historical and contemporary contexts that have influenced the development of these procedures. I conclude with a summary of the medical risks linked to FGCS and other genital surgeries to emphasize what is at stake when women undergo these procedures in the hope of overcoming various genital anxieties and/or to ‘enhance’ their sexual pleasure.

### **FGCS Nomenclature & Procedural Descriptions**

A major barrier to studying FGCS is the lack of terminological consistency and standardization (Goodman, 2009). Goodman (2009: 157) recommends that the medical community establish an official descriptive nomenclature for FGCS procedures before patented or proprietary terms<sup>6</sup> become entrenched in both medical and lay terminology. He (2009: 154) encourages the collective adoption of the following terms under the descriptive umbrella of ‘Female Genital Cosmetic Surgery’ (FGCS): labiaplasty, vaginoplasty, perineoplasty, hymenoplasty, and reduction of the clitoral hood. However, Goodman’s (2009: 158) recommendation for a universalized FGCS lexicon stems from a belief that doing so will enhance the legitimacy of patients’ requests for what he perceives as ‘reasonable cosmetic-enhancement procedures,’ because marketing terms have been seen to discredit the practice of FGCS. Findings from Liao et al’s (2012) analysis of the content and clinical implications of FGCS’ online advertisements support

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<sup>6</sup> Examples include: Laser Vaginal Rejuvenation (LVR), Designer Laser Vaginoplasty (DLV), Revirgination, and the G-shot. In addition, these procedures are ‘cheekily’ called ‘Designer Vaginas’ by the media and taken up into public discourse (Braun, 2009b: 234; Rodrigues, 2012: 779).

the need for implementing standardized terminology. These authors (2012: 2, 3) identify a total of 72 differently labeled procedures across 10 websites, which they suspect could be reduced into seven main categories of procedures.<sup>7</sup> This abundance of proprietary terms, along with a surprising omission of technical descriptions on FGCS provider websites, adds unnecessary confusion for potential patients. It also, I argue, impedes informed consent. Furthermore, the absence of universalized FGCS nomenclature makes it challenging for researchers to catalogue the exact number of FGCS procedures (Liao et al., 2012: 2-3). Liao et al. (2012) are not alone in their critique; the authors of the Society of Obstetricians and Gynaecologists of Canada's (SOGC) (2013: e5) report also argue that non-medical proprietary<sup>8</sup> terms should be recognized only as such, and stress that these procedures cannot be scientifically evaluated because they have no medical origin. This research highlights why it is crucial to develop and enforce a standardized nomenclature for these procedures.

Despite this lack of standardization, many scholars broadly define FGCS as a set of procedures designed to alter women's external and/or internal genital anatomy, primarily for the aesthetic 'enhancement' of the vulva (Braun, 2005a, 2009b; Goodman, 2009; Rodrigues, 2012; Schick et al., 2010; Weil Davis, 2002). Some FGCS procedures are purported to 'enhance' the sexual 'responsiveness' of the vagina, which - according to surgeons - allegedly results in increased sexual pleasure and satisfaction (Braun, 2005a, 2009b: 234; Goodman, 2009: 157; Rodrigues, 2012: 778). Similar to other elective

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<sup>7</sup> For instance, they argue the following terms may refer to the same procedure: 'vulval reshaping,' 'genital reshaping,' and 'vulva and vagina rejuvenation' (Liao et al., 2012: 3). Further, the following list of terms might designate the same procedure: 'hymen repair,' 'hymenoplasty,' 'hymen reconstruction,' and possibly 'revirgination' (Liao et al., 2012: 3).

<sup>8</sup> Examples included: Vaginal Rejuvenation, Clitoral Resurfacing, and G-spot enhancement (SOGC, 2013: e5).

cosmetic surgeries, FGCS procedures are typically undertaken on anatomically normal and healthy genitalia that lack any medical or functional indications for surgery, in order to ‘correct’ a perceived abnormal genital appearance (Braun, 2009b: 234; Lloyd et al., 2005: 643; Schick et al., 2010: 396).

Based on her work over the past decade, Braun (2009a: 134) concludes that, “all parts of women’s genitalia [are] subject to potential aesthetic (and “functional”) enhancement.” She (2009b: 233-234) summarizes the growing list of FGCS procedures as follows: 1) labiaplasty, labioplasty, or nymphectomy (the reduction of the labia minora to correct for asymmetry or protrusion beyond the labia majora), 2) vaginoplasty or ‘vaginal rejuvenation’ (tightening of the vaginal canal through muscle realignment or fat grafting), 3) hymenoplasty (hymen ‘reconstruction’ to restore the appearance of ‘virginity’ and to cause bleeding upon penile penetration during coitus – typically done to fulfill a religious or cultural marriage requirement), 4) hoodectomy (clitoral ‘unhooding’ or reduction) and/or clitoral repositioning, 5) perineoplasty (‘rejuvenation’ or tightening of a relaxed perineum for a ‘smoothed’ appearance), 6) vulvar lipoplasty (reshaping the labia majora through fat grafting, removal of loose skin or liposuction, which can also be applied to the mons pubis – pubic mound), 7) and the G-shot (a collagen injection into the anterior wall of the vagina to ‘amplify’ the G-spot’s sensitivity by temporarily enlarging this patch of tissue).

### **Emergence of FGCS – A Brief History of Western Female Genital Surgeries**

The practice of FGCS entered public consciousness and discourse in 1998 after two Los Angeles surgeons – David Matlock and Gary Alter – began publicizing a range of elective cosmetic procedures to ‘beautify’ the vulva and ‘increase sexual

responsiveness' (Havranek 1998; Kamps, 1998; Moran & Lee, 2013; Rodrigues, 2012: 778; Tiefer, 2008: 467; Weil Davis, 2002). Medical discourse on asymmetric labial correction surgery dates back as early as the 1980s, with Hodgkinson and Hait (1984) being the first to publish a medical journal article on aesthetic vaginal labiaplasty (Goodman, 2009).

Despite the relatively recent introduction of FGCS into wider public discourse, some physicians and scholars argue that FGCS procedures are not really 'new' or 'experimental' (Goodman, 2009: 154). Arguably, what is 'new' about FGCS is the idea that women themselves are becoming concerned with their vulvar appearance, sexual function, and orgasmic abilities (Goodman, 2009: 154). In this context it is important to acknowledge the long history of female genital cutting (FGC) and operations (FGOs) that have been performed by Western medical practitioners (Braun & Wilkinson, 2001; Green, 2005; Whitcomb, 2010). For example, the practice of medical female clitoridectomy began in Victorian England and continued into the mid-twentieth century throughout North America (Green, 2005: 160). This procedure was predominantly practiced on white middle-class girls and women in an effort to cure them of various practices defined as non-feminine behaviour, such as lesbianism, masturbation, and nymphomania, which were seen as symptoms of mental illness (Green, 2005: 160; Whitcomb, 2010: 12). Scholars have suggested that this early practice of FGC functioned as a form of social control to ensure the proper display of heteronormative gender and sexual behaviour in white women (Green, 2005: 160; Whitcomb, 2010: 12). The restrictive, heteronormative, and misogynistic aspects of female genital operations

*remain* an ongoing concern for scholars and activists concerning contemporary FGCS procedures.

Contemporary FGCS procedures developed out of various gynaecological surgical techniques that have been used to tighten the vaginal muscles and surrounding supportive tissues to correct for urinary incontinence (Green, 2005). More specifically, vaginoplasty grew out of the common practice of the ‘husband’s knot’ (Braun, 2009a; Kitzinger, 1994), which consists of an extra stitch being sewn into vaginal and perineum tears from episiotomies after a vaginal delivery (Braun, 2009a; Green, 2005). This procedure has been used since the 1950s to tighten the entrance of a woman’s vagina (Green, 2005). Physicians have discreetly referred to this procedure as “improving a *woman’s* well-being” (emphasis added, Green, 2005: 170), yet it is not unusual for physicians to inform their patients’ male partners that they “put in an extra stitch for [them];” nor is it uncommon to hear jokes about the vagina being ‘made new’ or ‘tailor made’ post-delivery (Braun, 2009a: 135). Braun (2009a: 135) argues that “these practices demonstrate that women’s genitals have been constructed as potentially inadequate or damageable, and improvable (through medical intervention).” The context for these procedures is the prevailing belief that vaginal childbirth ‘ruins’ women’s genitals (Braun, 2009a). This discourse can also be linked to the rise in elective caesarean sections in the West, which have been promoted, in part, to prevent vaginal sagging and maintain the vagina as ‘honeymoon fresh’ (Braun, 2009a: 135). These claims are explored further in Chapter 6, where I discuss the medicalization of vaginal laxity, relaxation, and ‘looseness.’

Modern gynaecological practice is also influenced by popular notions that the vulva is a site profoundly in need of medical treatment (Frueh, 2003; Kapsalis, 1997). J. Marion Sims, who is known as the ‘Father of Modern Gynecology’ and the ‘Architect of the Vagina’, writes in his autobiography: “If there was anything I hated, it was investigating the organs of the female pelvis” (quoted in Frueh, 2003: 144). This discomfort with female genitals is not limited to doctors; misogynistic ideas that the vagina is inherently ‘dirty’ are widespread. For example, feminist gynaecologist Christiane Northrup recounts, “Over the years, many patients of all ages and backgrounds have asked me during their pelvic exams, ‘How can you do this job? It’s so disgusting’” (quoted in Frueh, 2003: 145). Terri Kapsalis’s (1997: 92) analysis of the photographic depictions of female genitalia in medical texts describes a related discourse of abhorrence and revulsion of the vagina. Her research uncovers “only one instance of a photograph of healthy, normal female genitalia,” a discovery which led her to critique gynaecological medical training. She argues that “Medical students . . . have been indoctrinated into a system that privileges pathology” (Kapsalis, 1997: 72). Frueh (2003: 145) argues this repulsion towards the vagina has resulted in a medicalized and pathologized vagina being represented as unaesthetic, meaning that the vulva is almost always marked as ‘ugly’ and “by specificities of disease, discomfort, and complaint, [which] looms large in both cultural and women’s consciousness of vaginas.” This discursive trend conflates dysfunction and unattractiveness. In my analysis of FGCS websites in Chapter 6, I trace how the medicalization of women’s vulvas—where ‘undesirable’ appearance is linked with pathology—appears as a prominent legitimatizing theme in FGCS advertising in Canadian provider websites.

## **Dr. David Matlock – The Picasso of the Vagina & Pioneer of the FGCS Franchise**

David L. Matlock, who is heralded as the “The Picasso of the Vagina”<sup>9</sup> (*Harper’s Bazaar*, 2002 quoted in Frueh, 2003: 147; Kern, 2003: 53), is a Los Angeles-based gynaecologist and plastic surgeon. He is founder and CEO of the Laser Vaginal Rejuvenation Institute, where he performs his trade-marked Laser Vaginal Rejuvenation (LVR), Designer Laser Vaginoplasty (DLV), and G-Shot procedures. Matlock has garnered both world renown and professional scorn for his laser vaginal surgical techniques, because he employs a franchise model to market, license, and sell his FGCS procedures (Tiefer, 2008). This means, that other surgeons offering LVR, DLV, or the G-Shot have all been trained by Matlock, purchase his medical equipment, and pay licensing fees to him in order to run their own ‘Laser Vaginal Rejuvenation™ Institutes’ (Tiefer, 2008). Importantly, Matlock’s medical contemporaries have scathingly compared him to McDonald’s; they “condemn him for trademarking and franchising while publishing no scientific data” (Tiefer, 2008: 468). Matlock defends his unwillingness to publish data as a means to protect his intellectual property (Tiefer, 2008: 468). Despite the controversy, Matlock has profited immensely from this model as he averages 500 vaginoplasties per year since first pioneering his DLV procedure in 1996 (Kern, 2003: 52, 53).

The ‘origin story’ that Matlock promotes for the development of this model starts with his ‘discovery’ in 1988 that women’s sexual gratification was allegedly linked to their vaginal tightness (Green, 2005: 170). Matlock made this connection after receiving

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<sup>9</sup> At first this appears to be a fundamental misunderstanding of Picasso’s artwork, but Frueh (2003: 147) suggests, “Artists such as Picasso have their ‘trademarked’ styles” and it is therefore “interesting, from an aesthetic as well as a sales point of view, that Matlock has trademarked LVR (as well as DLV).”



an overjoyed phone call from a patient he operated on a week before for stress urinary incontinence, an outcome of having had four children (Green, 2005: 170-171). The woman allegedly thanked him profusely for improving both her and her husband's sex lives (Green, 2005: 170). Armed with this knowledge, Matlock developed his procedures by reconstructing "the lower third of the vagina; which includes the orgasmic platform, internal and external vaginal diameter (introitus) and the perineal body" (Green, 2005: 172). Consequently, the DLV procedure purports to enhance "vaginal muscle tone, strength and control, decrease internal and external vaginal diameters, and build up the perineal body" (Green, 2005: 172). Similarly, Matlock performs his LVR procedure to "bring the woman back to a point where she is post virginal and pre-child bearing" (Good Medicine, 2000: 3 quoted in Green, 2005: 172). This is achieved by "treating the loss of the optimum structural architecture of the vagina, the looseness of 'vaginal relaxation' that can result from childbirth, although some women are naturally looser—larger—than others" (Matlock, 2002a quoted in Frueh, 2003: 146).

Rodrigues (2012: 786) points out that vaginoplasty surgeries like LVR are performed entirely on the interior of the body, and do not produce a visible result on the body's surface. They are nevertheless classified as 'cosmetic' or 'aesthetic' procedures. Frueh (2003: 146) claims that this model of sexual pleasure – where more genital friction is equated with optimal sensation and stimulation – is interpreted by Matlock to mean that 'better' structure is equated with 'better' aesthetics. She (2003: 146) also contends that both DLV and LVR are premised on the beauty norm that connects aestheticization and rejuvenation, making LVR an aesthetic surgery, despite DLV being exclusively

marketed as enhancing the aesthetics of the vulva, whereas LVR is marketed as enhancing women's sexual satisfaction.

Whether or not LVR and similar vaginoplasty procedures should accurately be classified as 'cosmetic,' FGCS surgeons represent vaginoplasty using discourses that "construct the 'private' female body as a 'public' site for improvement, where improvement is both informed by and reproduces the 'cultural desirability of a tight vagina'" (Rodrigues, 2012: 786). This discourse produces a norm that many women cannot achieve without medical intervention, which is, of course, a desirable (and profitable) outcome for surgeons.

Matlock himself suggests that one of the benefits of having LVR or DLV is that "a tight vagina might help you keep your man from running after younger women" (Ollivier, 2000 quoted in Green, 2005: 172). Further, in an interview with a female reporter, Matlock expounded on similar themes: "Why not have the best sex you can at home?" with "You tell me why these 40, 50, 60-year-old men are running after younger women? They want these women with these nice, hot, tight\_\_\_\_\_" (Last word was removed in the original and potentially indicates the use of a derogatory or slang term for the vagina - Kern, 2003: 53).

In his YouTube videos, which chronicle his patented labial reduction procedures, Matlock repeatedly boasts that "She is like a 16-year-old now" (Tiefer, 2008: 469). Despite these sexist comments, Matlock claims to be a feminist, because he 'responds to women's stated desires', and therefore has a reputation amongst his patients for being a 'woman's doctor' (Frueh, 2003; Kern, 2003; Tiefer, 2008). Indeed, Matlock claims that his LVR procedure is "driven by women, and it's for women... The woman is the artist,

and we are the instrument she uses to express herself in her image” (Kern, 2003: 52).

Representing himself as one of the only doctors interested in “medical intervention to facilitate female sexual liberation and erotic equality” (Kern, 2003: 52), Matlock has argued that:

There are over 25 medications for male impotence...Is there anything remotely similar for women? No. Not at all. There are 200 prosthetic devices for men on the market. Anything similar for women? Not at all. If men had problems like that—if men had babies, and we had certain body parts stretched out as a result—they would have been looked at, researched and solved a long time ago (Kern, 2003: 52).

Despite Matlock’s superficial feminist sympathies, feminist scholars like Kern (2003: 53) argue that what he is actually offering women is the “reconstructed body as commodity.” Kern (2003: 53) claims Matlock’s advertisements for LVR and DLV “play on bodily fear and shame and promise an erotic utopia through vaginal rejuvenation” in ways that are actually exploitative and ‘anti-woman.’ She (2003) goes on to suggest that LVR is not designed to enhance female sexuality. Rather, it is yet another tool to prevent aging. She (2003: 54) also contends that, “the promise of the perfected female sexual body, marketed as a means to enhance female sexual pleasure only serves to reinforce the subordination of female desire to the needs of the male in the traditional patriarchal order.” In this context it is important to remember that, despite claims that these procedures improve women’s sexual pleasure, no published medical studies verify this theme. This gap points to the need for further scholarly work that explores how these procedures have been popularized, legitimated and marketed.

### **FGCS Demand & Media Influence**

Currently FGCS procedures are not in high demand. However, some statistics and anecdotal evidence from cosmetic surgeons suggest consumer demand is rapidly on the

rise and that this may be in part attributable to increased media attention (Bramwell et al., 2007; Braun, 2005a, 2009a; Braun & Tiefer, 2010; Braun & Wilkinson, 2001; Goodman, 2009; Green, 2005; Liao & Creighton, 2007; Renganathan, et al., 2009; Rodrigues, 2012). After conducting a literature review of labial reduction procedures, Liao et al. (2010: 22) found nearly 1000 published cases of cosmetic labial surgery. They suggest these figures likely underrepresent the true number of procedures conducted as the vast majority are “performed in the private sector, where audit and publication are not required” (Liao et al., 2010: 22). In Braun’s (2005a: 408) analysis of FGCS media coverage in magazines, one article professed that, “there is no question there’s a big trend, ... it’s sort of coming out of the closet. It’s basically where breast augmentation was 30 years ago.” Associating FGCS rates with breast augmentation is concerning, because it potentially places FGCS procedures on a similar trajectory toward popularity and wider societal acceptance. Furthermore, Liao and Creighton (2007: 1091) contend that growing demand for FGCS “may reflect a narrow social definition of normal, or a confusion of what is normal and what is idealized.” Therefore, they argue that the mere “provision of [cosmetic] genitoplasty could narrow acceptable ranges further and increase the demand for surgery even more” (Liao & Creighton, 2007: 1091).

Cosmetic surgery advertising began in the 1980s and 1990s, after government restrictions on physician advertising were removed in the United States (Tiefer, 2008: 468). Following the removal of these prohibitions, cosmetic surgeons began to use consultants for image management, promotion, and branding, and also hired public relations experts to secure positive media coverage in women’s magazines, often in exchange for providing free services to journalists (Tiefer, 2008: 468). Scholars studying

FGCS note the increasing coverage and visibility of these procedures in news and lifestyle media sources (Johnsdotter & Essén, 2010). The work of Koning et al. (2009) considers media influence on female attitudes of labia minora appearance and reduction. They found that nearly all of their participants<sup>10</sup> (95%) had become aware of labia minora reduction in the past 2.2 years, and that the majority of their participants (78%) had learned about labia minora reduction through a media source, including television, radio, magazines, the Internet, and newspapers (Koning et al., 2009: 65, 67). Connecting these findings to previous research on breast augmentation – which has shown that the demand for a procedure increases with the intensification of media coverage – it becomes clear that the rates for FGCS procedures will most likely rise in coming years (Koning et al., 2009: 70).

Koning et al. (2009: 69) argue that this expanding media coverage of FGCS may be creating a new problem: a heightened preoccupation and concern with the appearance of female genitalia. Their findings suggest an increase in demand for labiaplasty is likely, as 14% of their participants perceived the appearance of their labia minora to be abnormal, 7% had previously considered having a labia minora reduction, and 0.42% of the study's population had actually undergone such a procedure (Koning et al., 2009: 70). Overall, Koning et al.'s, (2009: 65) work highlights the important role that popular media plays in contributing to public attitudes about appearance, health, and sexuality, which inform individual decision making on elective cosmetic procedures such as FGCS.

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<sup>10</sup> Participants consisted of female medical students; patients visiting an outpatient Department of Obstetrics and Gynecology; and female patients visiting a private clinic. The study was conducted in The Netherlands.

## **Associated Risks of FGCS & Other Genital Surgeries**

All surgeries carry risks of medical complications (Johnsdotter & Essén, 2010: 33). However, there is mounting concern amongst policy makers and researchers that some “consumers have forgotten that cosmetic surgery procedures are surgery and carry potential risks and complications” (Hennink-Kaminski et al., 2010: 45). This collective amnesia extends to FGCS procedures. Surgeons continually downplay the risks, while exaggerating the benefits and ease of surgery (Braun, 2010, 2012; Liao et al., 2010; Moran & Lee, 2012). In Goodman’s (2009: 156) experience with FGCS patients, they often viewed labiaplasty as relatively risk and discomfort free, with few recovery difficulties. However, Goodman (2009: 156) stresses that “Because these procedures are relatively new and the literature investigating outcomes and risks relatively sparse, the possibility of other untoward outcomes must be discussed candidly.” These untoward outcomes and risks of cosmetic surgery vary, but can include: severe pain, scarring, nerve damage, hematoma, and even death (Leve et al., 2011: 137). More specifically, the possible negative physical outcomes, medical complications, and risks associated with FGCS are: postoperative dyspareunia,<sup>11</sup> postoperative pain and discomfort, altered or impaired sensation,<sup>12</sup> loss of sensitivity, painful intercourse, nerve damage, infection, poor wound healing or wound dehiscence from labiaplasty (often requiring a second corrective procedure), adhesions, scarring, excessive bleeding, haemorrhage, urinary tract infections, and sterility (ACOG, 2007; Braun, 2012; Crouch et al., 2004; Crouch et al.,

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<sup>11</sup> A relatively common, but usually temporary condition experienced by labiaplasty recipients. Rouzier et al. (2000: 38) note this is because labiaplasty “involves the vulvar canal in a similar way to an episiotomy.”

<sup>12</sup> This may be the result of the disruption of nerves and blood vessels, which can “impair sensation to the genital area and affect future capacity for sexual pleasure” (Crouch et al., 2004; Lloyd et al., 2005: 645; Minto et al., 2003).

2008; Goodman, 2009; Green, 2005; Lloyd et al., 2005; Minto et al., 2003; Rouzier et al., 2000). Additionally, Goodman (2009: 156) notes that the overtightening of a vaginal orifice can occur through perineoplasty, while patients undergoing vaginoplasty face the added risks of bowel or bladder entry and/or the risk of producing incontinence from the alterations performed on the anterior or posterior compartments of the vaginal canal.

Here the literature on intersexed women's experience provides additional insights. For intersexed women with 'atypical' genitalia – for whom, unfortunately, 'corrective' genital surgery is an all too common practice – it is clear that surgical incisions to the labia minora endangers sexual sensitivity (Berman et al., 1991; Liao & Creighton, 2007: 1091). Sexual sensitivity is jeopardized because the labia minora are comprised of highly sensitive nerve fibres, which contribute to women's erotic sensation and pleasure when the labia become engorged during sexual arousal (Berman et al., 1991; Liao & Creighton, 2007: 1091). Research on intersexed women has shown that "clitoral surgery is associated with [an] inability to reach orgasm" (Liao & Creighton, 2007: 1091; Minto et al., 2003), and "impaired sensitivity is specific to the site of surgery" (Crouch et al., 2004; Liao & Creighton, 2007: 1091). Any genital surgery "risks disruption of nerves and blood vessels, which may impair sensation to the genital area and affect future capacity for sexual pleasure" (Lloyd et al., 2005: 645). Further, the surgical reduction of labial tissue removes sexually sensitive tissue and pleasurable nerve endings, which may subsequently result in "lifelong hypersensitivity or numbness, pain on intercourse, infection, adhesions and scarring" (Chalker, 2009). Therefore, Liao and Creighton (2007: 1091) stress that any kind of genital surgery can potentially cause a loss of sexual

sensitivity, which is an ironic outcome for surgeries that are often purported to increase sexual pleasure.

Anecdotal accounts from surgeons and FGCS patients confirm that these risks or ‘undesirable consequences’ are common. Dr. Laura Berman, who treats women for sexual dysfunction, reports that, “some of her patients complained that they ended up with pain, or could no longer be sexually aroused after undergoing some of the procedures. Unlike most other cosmetic procedures...genital plastic surgery has the potential to harm function” (as quoted in Navarro, 2004). She adds for further emphasis that, “Any time you're having surgery that involves any kind of intervention in the genitals you're asking for trouble in regard with [sic] your sexual function” (as quoted in Navarro, 2004). Other plastic surgeons and physicians have been equally vocal in their condemnation of these procedures. Dr. Malcolm Lesavoy, who teaches plastic surgery at ULCA, clearly states that, “anytime you make an incision, nerves are cut [and] for that reason, you can have decreased sensitivity” (quoted in Scheeres, 2006: 264). Therefore, he cautions against cosmetic genital surgeries (Scheeres, 2006: 264). Plastic surgeon Dr. Stephen Mulholland similarly warns that surgical risks are high, and that their benefits to women are unproven (as quoted in Green, 2005: 175). Kenneth Glassber, a paediatric urologist, also states that a “good cosmetic appearance does not guarantee good sexual function” (as quoted in Green, 2005: 175). Similarly, Braun (2012) has found women on online health forums<sup>13</sup> warning others of their negative experiences, which are often linked to the all-too-common practice of overzealous surgeons removing the labia minora

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<sup>13</sup> Braun (2012) offers the following two websites as examples of women’s online narratives around their negative experiences with FGCS: [http://www.steadyhealth.com/Labiaplasty\\_Nightmare\\_t112049.html](http://www.steadyhealth.com/Labiaplasty_Nightmare_t112049.html) <http://www.experienceproject.com/groups/Had-Labiaplasty/106234>



entirely,<sup>14</sup> even against some of these women's expressed wishes. In 2007 a Swedish woman went as far as to file a report with the Medical Responsibility Board, because she felt mutilated after "too much tissue had been removed from her labia and clitoris during cosmetic surgery on her genitals" (Johnsdotter & Essén, 2010: 33).<sup>15</sup> Overall, these anecdotal accounts show that FGCS procedures *can* and *do* cause significant distress and severe/irreversible damage and harm to women, while nothing is known of their long-term impacts, including obstetrical experiences and outcomes (Braun, 2012: 36). These statements clearly contradict the claims that FGCS procedures enhance female sexual pleasure by suggesting that they put women's wellbeing, health, and sexual pleasure at risk.

Given this context, Liao et al. (2010: 23) stress the need for additional longitudinal research examining obstetric complications resulting from FGCS procedures. Their concern about the potential increase in obstetric complications stems from the fact that the genital tissue removed during labiaplasty is comparable to types I and II of traditional female genital cutting, which have been linked to perineal trauma, postpartum haemorrhage, and increased neonatal death (Liao et al., 2010: 23). These authors concede that, "though a planned caesarean section may circumvent risk, it is [nonetheless] important to bear in mind that many of the nations in which cosmetic labial surgery is being marketed are also those with unacceptably high caesarean section rates" (Liao et al., 2010: 23). In addition, they note that, "it is difficult to predict how a young woman seeking labial surgery now will feel about the increased likelihood of a caesarean section in 10 or 15 years" (Liao et al., 2010: 23). Therefore, future gynaecological and

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<sup>14</sup> May be marketed as the 'Barbie.'

<sup>15</sup> A formal warning was issued to the surgeon (Johnsdotter & Essén, 2010: 33)

obstetric complications and risks should be made explicit to potential FGCS patients to ensure they are fully informed. Women contemplating labiaplasty should also be made aware of the wide range of variation in genital morphology and appearance (Lloyd et al., 2005: 645).

It is ironic, as Green (2005) points out, that healthy women would risk their sexual functioning and physical health in the belief that they can ‘enhance’ their sexual pleasure by electing to have cosmetic genital surgery. However, we must acknowledge that there are real symbolic risks involved in *not* having surgery as well (Leve et al., 2011: 137). Leve et al. (2011: 137) connect these symbolic risks to “the obligation [for women] to construct a ‘feminine’ body through socially sanctioned practices, which for many women is essential to constructing an external appearance that corresponds to their embodied sense of self” (see also Bartky, 1990). Schick et al. (2010: 394) assert that “women have been socialized to value their physical appearance as [an] integral component of their sexuality” and that “women equate the essence of womanhood with the appearance of their sexual organs” (Polonijo & Carpiano, 2008: 467). Therefore, Leve et al. (2011: 137) argue that some women who undergo cosmetic surgery “privilege the symbolic rewards of a normative feminine body over the potential material risks to [their] physical body.” Leve et al.’s (2011) argument is in relation to more observable feminine characteristics, for example, physical traits that are not hidden under clothing. However, the principles are comparable for genital anxieties, as they are equally central to women’s embodied sense of self.

## **Chapter 3 –Theoretical Orientations**

### **Social Constructionist Theory**

#### **Social Constructionist Account of ‘Choice’**

A materialistic feminist social constructivist ontology frames this project because it allows me to explore the influence that socio-cultural representations have on the production of individuals’ social, symbolic, and material realities, as well as on individual’s preferences, behaviours, and practices (Braun, 2005a: 409). A social constructionist perspective acknowledges that the meanings ascribed to objects are not inherent or fixed, but rather develop and change over time (Braun, 2009a: 136; Braun & Wilkinson, 2001: 18). Feminist scholars have often applied this theoretical framework to their analyses of contemporary beauty practices such as cosmetic surgery, as it allows them to understand the impact that societal pressures and/or expectations have on women’s gendered experiences of embodiment, and their oppressive or liberatory implications (Braun, 2009a: 136). The social constructivist perspective I employ acknowledges that discourses, norms, and subjectivities have real material impacts and consequences for women’s bodies, sexual expression, and embodiment. Therefore, from this theoretical viewpoint, FGCS provider websites are problematic, most notably because they contribute to and reproduce contemporary notions of ‘pudendal disgust’ (Tiefer, 2008), along with ‘functionalist’ and heteronormative discourses related to women’s sexuality. The purpose of these discourses is to construct and market women’s genitalia as a potential and legitimate site of distress that cosmetic surgery alone can fix (Braun, 2009a: 142). Therefore, any analysis of FGCS needs to be anchored in a feminist social constructivist critique.

## **The Cultural Construction and Limitations of ‘Choice’**

Because these surgeries are ‘chosen’ by adult women it is crucial for me to ground my argument that FGCS is a social justice issue in an analysis of the ways individual choice must be situated in a broader cultural landscape structured by misogynist and heteronormative ideals about the female body. Drawing on the work of feminist philosophers, I argue that notions of choice are much less ‘free’ than we are initially lead to believe (Chambers, 2008: 28). The most significant limitation of the liberal conception of justice defined as ‘free choice’ is “its inability to acknowledge how social norms, desires, preferences, agency, and choice are socially constructed, [along with] the external conditions that enable and restrain them” (Hirschmann, 1996: 48). Social constructivist theorists claim that when an individual makes a choice or engages in a particular practice, they are participating in a social form and mediated by larger cultural discourses (Chambers, 2008: 38). Overall, liberal framings of choice support and protect people’s freedom to make choices that threaten their well-being and equality; whereas social constructivist theory critically analyzes how one’s choices and options can be constrained and influenced by external forces and cultural norms (Chambers, 2004: 13; Chambers, 2008: 159). I argue that liberal approaches may reproduce gender inequality insofar as they perpetuate discourses that reinscribe oppressive hierarchical power structures and relations that subordinate certain groups of people through the rhetoric of individual ‘choice.’ As such, social constructivist theory is crucial to defending my claim that FGCS is indeed a legitimate social justice issue that demands a critical evaluation of the structures of choice and desire involved in its practice (Chambers, 2008: 168).

The work of Clare Chambers is helpful for dismantling the problematic nature of the choice rhetoric employed by FGCS provider websites. Chambers (2008: 38) explains why individual choice cannot render an outcome just, even when enacted against a background of liberal equal opportunity. Drawing on Foucault, she argues that culture comprises everyday practices, and by choosing to enact a specific practice, an individual may be engaging in a social form that is larger than their individual intentions, nor is desire to partake in a practice completely knowable (Chambers, 2008: 39). In other words, practices can never be separated from culture and the normative and just nature of the practice cannot be determined solely by one's decision to partake in it (Chambers, 2008: 39). The simple application of choice does not render an outcome just; because there are instances where a 'chosen' practice perpetuates inequality (Chambers, 2008: 39).

Chambers (2008: 39) expands on the inability of choice to render an outcome just by tackling the question most often posed by liberals: if a woman chooses to have cosmetic surgery<sup>16</sup> *for herself* and not for anyone else, wouldn't that make the decision just? Chambers (2008: 39) acknowledges that many women who have elective cosmetic surgery claim that they are undergoing the procedure for themselves, and adamantly deny that they may be doing it to appease their male partners or to make themselves more attractive to men. She argues that women's endorsement of 'choice' rhetoric for cosmetic surgery is not the same as saying they are impervious to patriarchal and misogynistic norms (Chambers, 2008: 39). The only way one could claim that a woman's desire for cosmetic surgery – or in the case of my research, FGCS – is independent of patriarchal

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<sup>16</sup> Chambers uses breast augmentation as her example, but notes that any other elective cosmetic procedure - such as FGCS – could be used in its place.

norms is if she were to live in a non-patriarchal society (Chambers, 2008: 39). Until women reside in a society that is divorced from patriarchal and misogynistic influences, women's motivations along with the meanings of a practice and its subsequent effect on other people will remain opaque. As such, she argues that a woman's 'choice' or decision remains irrelevant to the conception of justice (Chambers, 2008: 39-40). More specifically, the practices we engage in are social and take place in a cultural context, and in turn are dependent on that context for their meanings (Chambers, 2008: 40). Consequently, practices cannot only be defined on the basis of "the meanings that an individual wants them to have, either for herself or for others" and therefore cultural injustice cannot simply be dismissed by the argument of individual choice (Chambers, 2008: 39).

Chambers' (2008: 263) criticisms of liberal theorists' tendency to view 'choice' as a normative transformer<sup>17</sup> remains relevant when applied to a secondary component of social construction – the construction of *options* that are available to individuals. Chambers (2008: 263) maintains that "even a perfectly rational, freely choosing individual is constrained by the fact that she must choose from the options that are available to her, and that are cast as appropriate for her." In other words, the options a woman finds available may themselves be limited or violate her well-being or equality by demanding that she harm herself in order to receive some benefit when no such expectation is required nor demanded of other individuals (Chambers, 2008: 263). I agree with Chambers' (2008: 265) argument that social norms can encourage individuals to harm themselves. Chambers (2008) explains that the problem here is not one of

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<sup>17</sup> Chambers (2008: 263) defines a normative transformer as "a concept that renders an outcome just by its presence."

individual choice, flawed reasoning, or psychology, but rather of a societal nature, which means the wrong can more adequately be amended through social action and societal change (Chambers, 2008: 265-266). In sum, social construction criticizes empiricism for its imperviousness to (a) *options* that are available to be chosen by individuals, and (b) *preferences and beliefs* that inform one's decision to choose one option over another (Chambers, 2008: 93).

### **Concerns, Criticisms and Critiques of Social Constructivism**

#### **Social Construction and the 'Cultural Dope'**

Overall, I claim that social constructivist theory is both useful and troubling in my assessment of the problems associated with FGCS. The application of social constructivist theory becomes troubling when it suggests that, "the desires and preferences women have and the choices they make are determined to a large degree by a context that has women's subjugation at its core" (Hirschmann, 1996: 53). Hirschmann (1996: 53) suggests that because we become who we are through processes of social relations, and that these social relations typically construct women in negative and demeaning terms, consequently it becomes "'only human' for women to internalize them, to give them some credence, [and] to accept them as 'truth.'" Ultimately, this can leave women second-guessing their 'true' desires and motivations, and casts women as victims of false consciousness (Chambers, 2008: 87-88).

These 'hard' social constructionist accounts of women's embodiment influenced the earliest feminist critique of cosmetic surgery and its unanimously critical position. Originally, feminists regarded cosmetic surgery as "a particularly pernicious expression of the disciplinary regimes of the feminine beauty system – [and] as [a] way, quite

literally, to ‘cut women down to size’” (Davis, 2003: 59). Furthermore, the long-standing feminist critique of cosmetic surgery found the industry represented an exceptionally reprehensible set of beauty practices, because it risked women’s health in order to sustain cultural notions of feminine inferiority (Davis, 2003: 3). In addition to this, initial feminist theorizing on cosmetic surgery also tended to portray women seeking elective cosmetic surgical procedures as “‘misguided or deluded victims’ of patriarchal social forces” (Dolezal, 2010: 371). Kathy Davis (2003: 74) characterizes this earlier feminist position on cosmetic surgery as follows:

Whether blinded by consumer capitalism, oppressed by patriarchal ideologies, or inscribed within discourses of femininity, the woman who opts for the “surgical fix” marches to the beat of a hegemonic system—a system that polices, constrains and inferiorizes her. If she plays the beauty game, she can only do so as a “cultural dope.”

Davis’ first book on cosmetic surgery, *Reshaping the Female Body* (1995), evoked much controversy amongst feminist scholars, as she is openly critical of the initial feminist position for simply rejecting cosmetic surgery. She defends women’s agency and ability to make rational choices, and critiques scholars for dismissing women’s narratives of self-determination and the liberating and transformative effects of cosmetic surgery (Davis, 2003; Dolezal, 2010; Gillespie, 1996). Davis also questions the usefulness of a feminist critique that characterizes women as duped by the system, highlighting that it cannot explain why many intelligent, educated, and even *feminist* women engage in these practices (Davis, 1995; 2003; Dolezal, 2010: 371). Here Davis erroneously implies that ‘intelligent, educated, and feminist’ women are somehow above or removed from cultural influence. Braun (2009b: 244) has a different emphasis as she develops a social constructionist position that “each individual [woman] exists within a discursive,



material, and experiential context –both contemporary and historical—that is simultaneously *unique* to her, and socially patterned (and thus shared).” In agreement with Braun (2009b) I argue that individual women and men are both influenced by the contemporary context in which they are embedded, and yet also possess individual agency in the choices and decisions they make. For example, not all women dissatisfied with their genitalia choose FGCS, whereas others choose to participate in cultural practices that objectify and sexualize them (Bordo, 1993: 189; Braun, 2009b: 244; Gillespie, 1996: 80). As Braun (2009b: 244) notes, the problem in Davis’ work lies in her inability to sufficiently explain why so many women seemly make the same choices for such similar ‘personal’ reasons. As ever-increasing numbers of women decide to undergo FGCS procedures, we need to shift our analytic lens beyond the individual in order to critically assess the wider societal and systematic influences and pressures to which women as a group are subjected. Parker (2010: 55) also argues that Davis’ focus on individual women’s agency in relation to cosmetic surgery minimizes the undeniable cultural and structural factors that influence and reinforce women’s dissatisfaction with their appearance. Similar to Chambers’ (2008: 9), I aim to avoid the tendency of liberal and postfeminist thinkers like Davis – to exclusively concentrate on “the extent to which individuals are able to choose and act autonomously and pay no consideration to how society forms people’s preferences or to how people’s preferences affect society.” I argue that if ‘choice’ becomes the sole determinant of justice, then we run the risk of “being bound by decisions that result from various forms of social domination or oppression” (Chambers, 2008: 10).

## Rejecting the Notion of an Essentialist Female Nature

Chambers (2008: 89) relies on Nancy Hirschmann's account of social constructivist theory,<sup>18</sup> which is combined with an explicit feminist normative focus, in order to help her articulate how it is possible to "reject the idea of an essentialist female nature while at the same time arguing that some beauty norms are more realistic, more "true" than others." Chambers (2008: 89) argues that, "womanhood may not have a conceptual, all-encompassing "truth," but women are concretely embodied, and the nature of women's bodies can be more or less truthfully represented." For example, Chambers (2008) describes how the extremely thin beauty ideal for women in the West inaccurately represents the diverse range of the female form. Chambers (2008: 89-90) also claims that "a society that finds only youthful faces beautiful requires women to...[misrepresent] themselves if they wish to...appear beautiful throughout their lives, whereas a society that sees beauty in all ages allows women's self-representations to be more truthful." Through these examples, Chambers (2008: 90) reconciles how feminists employing social constructionist theory to critique western beauty practices can on the one hand refuse the existence of a universal or essentialist female nature, while on the other still maintain that, "bodies do have a concrete form, which can be more or less contorted and falsified." According to Chambers (2008: 90), cosmetic surgery symbolizes "the falsification of the body, and the misrepresentation of the individual whose body it is, *par excellence*—for its results cannot be achieved by the natural processes of the transformed body (as occurs with diet and exercise) but are consciously constructed by the surgeon in line with particular norms of beauty." Furthermore, cosmetic surgery often

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<sup>18</sup> Hirschmann explains social constructivist theory by dividing it into three levels: 1) the ideological misrepresentation of reality, 2) materialization, 3) the discursive construction of social meaning (Chambers, 2008: 87-93).

requires inserting foreign substances<sup>19</sup> into the body in order to achieve these ‘ideal’ forms (Chambers, 2008: 90), as well as the physical amputation or removal and/or replacement of bodily tissues.<sup>20</sup>

Margaret Olivia Little’s (1998: 167) work supports Chambers (2008) defense of social constructionist theory as she recounts how historically, “woman and the ‘feminine’ [have] been cast in roles of contamination, infection, and danger.” In turn, the resulting hostility towards distinctly feminine features was, and arguably still is, reproduced in feminine appearance norms (Little, 1998: 167). Little (1998: 167) contends that, “in some cultures, it appears as a hatred of female fat, in others, as a hatred of female body hair,” and I would also argue in the West as a hatred of female genitalia. Little (1998: 167) claims that, “women’s norms of appearance tend to be farther from the natural, the average, or the usual than are men’s (e.g. fewer decades of a woman’s life than a man’s count as candidates for beauty) a point that helps explain why women’s standards of appearance are usually much harder to meet than are men’s.” Therefore, Little (1998: 167) holds a position similar to that of Chambers, as she concludes that, “the norms of women’s appearance reflect...distorted, unjust conceptions of woman herself.” In returning to Chambers (2008: 90) work she contends that, “even if there is no ‘truth’ to women’s nature, there are still grounds to discriminate between alternative norms, such as standards of beauty, on the grounds that some are more compatible with women’s equality and well-being than others.” I argue FGCS is a perfect example of a beauty norm that dictates a narrowly acceptable ideal to women, one that excludes the vast majority of

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<sup>19</sup> Such as silicone or saline implants and collagen or Juvéderm injections.

<sup>20</sup> For example, liposuction of fat cells, the removal of large sections of sagging/loose skin in tummy tucks, arm lifts, breast lifts, etc., and the removal of fat cells from one area of the body being reinserted into women’s breasts and buttocks.

women's natural genital morphology and thus requires surgical intervention in order to obtain a normative ideal.

### **Recognition of the Racist, Ageist, Able-ist, and Heterosexist 'Normate'**

Despite Chambers' articulation of the 'falsification' of the female form, her work would benefit from a more explicit acknowledgement that the dominant aesthetic ideals among cosmetic surgery recipients (including FGCS recipients) are racist, ageist, and able-ist, rather than just suggesting they lack an appreciation of women's bodily diversity (Bordo, 1993: 189; Dolezal, 2010: 367; Gillespie, 1996: 80; Heyes, 2007b: 99; Negrin, 2002: 27). Luna Dolezal's (2010) work focuses on contemporary Western feminine beauty norms in a phenomenological examination of cosmetic surgery and women's desire for bodily invisibility. Bodily invisibility is achieved by conforming to society's accepted feminine beauty ideals. Women attain bodily invisibility by adhering to the fastidious and restrictive social norms of bodily comportment and appearance that constitute the 'normate.'<sup>21</sup> The normate is defined as "the corporeal incarnation of culture's collective, unmarked, normative characteristics" (Garland-Thomson 2004, as quoted in Dolezal, 2010: 365), that "has a certain 'corporeal configuration' that yields 'cultural capital'" (Dolezal, 2010: 365). The normate in contemporary Western society refers to "young, heterosexual, Anglo-Saxon, slim, able-bodies, with symmetrically proportioned features and smooth, unmarked skin" (Dolezal, 2010: 365). The normate or 'normal' feminine body has become increasingly conflated with the 'beautiful' body, whose features are "dictated by gender, race, ethnicity, sexuality, class and ability systems that exert tremendous social pressures through various means, such as mass media, advertising, and medical discourse" (Dolezal, 2010: 365). Other feminist scholars

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<sup>21</sup> Term coined by Garland-Thomson (2004).

have similarly characterized normative definitions of feminine beauty as comprising a white, youthful, middle class, [hetero]sexualized, Western aesthetic that appears both ‘neutral’ and ‘unmarked’ (Braun & Wilkinson, 2005: 510; Dolezal, 2010: 367, 365; Negrin, 2002: 27), and excludes anyone who appears disabled, queer, fat, ethnic, or raced (Dolezal, 2010: 365). There is no denying that Western normative definitions of feminine beauty or conceptions of the normate are profoundly exclusionary and racially, and heterosexually inflected (Bordo, 1993: 189; Gillespie, 1996: 80).

Dolezal (2010: 365) acknowledges that the contemporary normate for feminine beauty is so narrowly defined that it describes only a minority of actual people, yet it is disproportionately represented in our image-saturated culture through the ubiquitous coverage of celebrities, models, and other public figures that embody the normate. According to Dolezal (2010: 365), flawless feminine images have “become emblematic of the dominant reality, setting the standards for normal bodies.” Therefore, the pervasive cultural messages it transmits of physical attractiveness through the perfected and digitally enhanced representations of the normate has imposed bodily standards on everyone (Dolezal, 2010: 365). These standards are becoming increasingly unreal in both their demands and expectations (Dolezal, 2010: 365). As women [and men] become gradually habituated to these normative representations, physical attractiveness and beauty in turn become increasingly equated with normalcy, as people begin both to expect bodily ‘perfection’ of themselves and others, while finding non-normative or non-conforming appearances defective, repellent, and unacceptable (Dolezal, 2010: 364).

As biomedical and beauty discourses converge in the West, medical definitions of health and pathology are increasingly framing aged, overweight, or ‘unattractive’ bodies

as unhealthy and in need of medical intervention (Dolezal, 2010: 367), as we see in the pathologization and subsequent treatment of women's 'unattractive' genital morphology by the FGCS industry. Dolezal (2010: 367) concedes that the above associations are neither entirely arbitrary nor subjective indicators of optimal health, as good health is often attendant on a 'robust' external appearance, which is comprised in part by a muscular form and good teeth among other features. Nevertheless, racist, ageist, able-ist, and consumerist discourses shape medical understandings of health and pathology, which have detrimental impacts on women's embodied experiences and self-esteem (Dolezal, 2010: 367). The normate informs women's and physicians' views about what constitutes healthy and attractive female genitalia, which the majority of women cannot achieve without medical intervention, thus ensuring the profitability of the FGCS industry with its potentially expansive pool of potential patients.

Based on the representations found in the mainstream image industries (including advertising and pornography) the contemporary genital ideal for women is that of a young (prepubescent) girl who has a 'slit' with no protruding or wavy labia minora, with a symmetrical shape, but also flushed to an 'arousing' and 'homogeneous' pink, which does not appear darkened with age or skin pigmentation<sup>22</sup> (Weil Davis, 2002: 15). This ideal excludes many women of colour, and older or postpartum women. In the following chapter, I review the existing literature on the pathologization of women's genital anatomy, and explore its racist, ageist, and heterosexist implications.

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<sup>22</sup> There are 'genital cosmetic colorant' products on the market that lighten the 'discolored' or 'darkened' genital tissues of the vulva that may result from hormonal changes or ageing. There are also products sold to 'restore' the 'pink' of women's genitals and come in multiple pink hues. Product examples include: My Pink Wink Cream (<http://mypinkwink.com/>); Pink Privates Intimate Area Lightening Cream (<http://pinkprivates.org/>); Pink Daisy Bleaching Cream; Clean and Dry Intimate Wash (<http://cleananddry.in/index.php>); and My New Pink Button (<http://www.mynewpinkbutton.com/>).

## **Chapter 4: Literature Review**

### **Introduction**

In this chapter, I provide further contextualization of the cosmetic surgery industry and FGCS in particular, through a detailed review of existing feminist research on women's reasons, motives, and indications for undergoing FGCS procedures, and highlight the feminist critique on the medicalization of appearance and sexuality. I conclude with a discussion on why more accurate and diverse representations of women's genitalia are important to women's sexual health.

### **Reasons, Motives, and Indications for Surgery**

The literature on FGCS suggests that women's decisions to undergo FGCS procedures are most often motivated by three main concerns: 1) 'aesthetic' (women's perceptions of an abnormal or defective appearance, particularly the visibility/protrusion and symmetry of the labia minora), 2) 'functional' or 'physical' (women's feelings of vaginal laxity or 'looseness', lack of sensation, genital friction or 'gripability' resulting in diminished sexual pleasure; chafing, irritation, and discomfort when wearing tight clothing or when engaging in physical activities and exercise (i.e. participating in sports, jogging, bicycling, etc.), problems with hygiene and 'odour' due to longer labia in tight clothes (i.e., may cause chronic yeast infections, recurrent urinary tract infections), difficulty with tampon insertion, and invagination of excess labial tissue during coital penetration), 3) 'psychological' (social and sexual embarrassment and inhibition, i.e., problems going to the beach, taking communal showers), avoidance of certain sexual practices or positions (i.e., losing one's virginity, cunnilingus, having intercourse with the lights on, etc.), and low genital self-esteem, confidence issues, and desire for improved

sex life and/or pleasure)<sup>23</sup> (Bramwell et al., 2007; Braun, 2010, 2012; Goodman, 2009: 156; Green, 2005; Liao & Creighton, 2007; Liao et al., 2012; Miklos & Moore, 2008; Moran & Lee, 2013; Navarro, 2004; Rodrigues, 2012: 786; Rouzier et al., 2000; Whitcomb, 2010: 17). However, surgeons' anecdotal evidence<sup>24</sup> and the existing literature on women's motivations for FGCS focuses predominantly on labiaplasty, thus emphasizing women's 'aesthetic' and 'cosmetic' genital concerns (Bramwell et al., 2007; Braun, 2010, 2012; Goodman, 2009; Goodman et al., 2007; Miklos & Moore, 2008; Rodrigues, 2012). This is unsurprising, as labiaplasty is the most common FGCS procedure (Braun, 2010) and continues to grow in popularity (Crouch et al., 2011; Moran & Lee, 2013). Bramwell et al.'s (2007: 1497) interviews with six women who had undergone surgery for labial reduction<sup>25</sup> suggest that the two most influential factors behind women's desire for labiaplasty were "their perceptions of an abnormal or defective appearance and the impact of their labial appearance on their sex lives." The work of Lloyd et al. (2005: 643) indicates that the reasons why women who lack an underlying genital medical condition seek surgery to change the appearance of their genitals are far from understood. Nevertheless, they propose that "implicit in a woman's desire to alter [her] genital appearance may be the belief that her genitals are not normal, that there is such a thing as [a] normal female genital appearance, that the operating surgeon will know what this is, that he or she will be able to achieve this for her and that this would somehow improve her wellbeing or relationships with others" (Lloyd et al.,

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<sup>23</sup> Women's reasons for undergoing hymenoplasty are separate from this list. Hymenoplasty is typically undertaken "to comply with cultural mandates for physical evidence of virginity at marriage" (Essén et al., 2010) or as an anniversary present for a spouse (Braun, 2012: 34).

<sup>24</sup> Dr. Alter, a prominent FGCS surgeon based in the United States, asserts that 90% of his labiaplasty patients undergo the procedure for cosmetic reasons, whereas less than 10% of his patients require the procedure for a "legitimate physical need" (Loy, 2001 quoted in Green, 2005: 173).

<sup>25</sup> The study was conducted at the British National Health Service Hospital.



2005: 643). Clearly more research is needed to understand women's motivations for engaging in FGCS, but equally important is a critical examination of the factors that contribute to popular views and assumptions about what constitutes 'normal' genital morphology for women (Liao & Creighton, 2007: 1090).

### **Strategic Emphasis on 'Functional' and 'Physical' Concerns**

It is also important to consider that some research suggests that women's verbal reports of vulva discomfort may be problematic indicators for treatment (Liao et al., 2010: 23). In Bramwell et al.'s (2007: 1496) retrospective qualitative study of six women whom had undergone labiaplasty, one participant confessed to prioritizing and emphasizing the 'physical difficulty' she sometimes experienced with her labia. This participant explained that she anticipated challenges and resistance in "gaining access to labial reduction surgery, at least within the NHS,<sup>26</sup> as she felt [the procedure] would not be provided on the basis of her dissatisfaction with her genital appearance alone" (Bramwell et al., 2007: 1496). Bramwell et al. (2007: 1493-1494) suggest that some women seeking FGCS procedures "may see medical staff as 'gatekeepers' and tailor their reasons for seeking surgery accordingly." Other participants in the study did not discuss using this approach to access the procedure. Nevertheless, when they spoke to referral agents within the healthcare system, the physical and functional aspects were presented as adding legitimacy to their requests for intervention<sup>27,28</sup> (Bramwell et al., 2007: 1496).

Fraser's claim that cosmetic surgery discourse guards against accusations of vanity

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<sup>26</sup> The NHS (National Health Service) is the publicly funded healthcare system for England.

<sup>27</sup> Interestingly, it has been reported that the number of labiaplasties performed by the NHS increased by 70 per cent in 2008 (Lenti, 2013).

<sup>28</sup> Labiaplasty is not typically covered in Canada; however, exceptions can be made in Ontario and British Columbia. In these two provinces labiaplasty can be covered in cases of medical necessity (i.e., where larger labia cause genital discomfort and pain) (Lenti, 2013). Therefore, it might be economically advantageous for women in these regions to strategically emphasize physical concerns, regardless of their validity.

(Braun, 2005b) may also help us understand why some women seeking FGCS may want to emphasize their physical, sexual, and functional concerns over strictly aesthetic ones.

### **Gender and the Context for FGCS**

Some scholars have questioned the gendered social context that produces requests for surgical intervention. For example, Liao et al. (2010: 22-23) suggest that cisgender men “tend not to complain about physical symptoms associated with genital protrusion despite potentially having more reason to do so.” In another article, Liao and Creighton (2007: 1091) stress that, “Men do not usually want the size of their genitals reduced”<sup>29</sup> and have found “alternative solutions for any discomfort arising from rubbing or chafing of the genitals.” These comparisons suggest that the removal of women’s sensitive labial tissue must be understood in the context of hegemonic gendered norms of attractiveness that shape our lived and embodied experiences. For example, it is expected that a man would not elect to remove or reduce his genital tissue, despite potentially experiencing more genital discomfort than women, because in Western culture a man’s masculinity and sexual prowess has been linked to the size of his penis. As the introductory quote by Germaine Greer highlights, men’s genital distress goes in the opposite direction of women’s; they worry that their penis is not large enough. Indeed, to suggest a cisgendered man would contemplate reducing the size of his genitals due to discomfort or chafing seems unimaginable in our current cultural context.

Women’s growing preoccupation with their physical appearance should be understood in the context of the growing legitimacy of all cosmetic surgeries (Gillespie, 1996: 83). Gillespie (1996) argues that medicine has expanded its practice to include

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<sup>29</sup> Larger penises are seen as being more sexually desirable and better capable of providing sexual pleasure than average or small sized penises (in terms of both penile girth and length). Men’s penises are also linked to notions of masculinity and one’s manhood, with more meaning better.

aesthetic treatments in response to the growing levels of bodily preoccupation in Western society. In turn, the increased medicalization of female appearance serves to: 1) make women's bodily preoccupation a 'normal feminine behaviour', 2) encourage women to experience their bodies through a pathological lens, 3) reinforce unrealistic ideals, and 4) maintain gender inequalities (Gillespie, 1996: 83). In recent years, women's bodily preoccupation has extended to their genital appearance, which some scholars attribute to a prevailing 'hyperesthetic' for sexual attractiveness in the West (Green, 2005: 173). Rodrigues (2012: 790) claims that, "the standards for sexual attractiveness have become so increasingly precise as to incorporate concerns [of] vulval aesthetics." Indeed, vulval self-consciousness may have also been exacerbated by contemporary fashion trends, including skimpy swimsuit styles and thong underwear, which draw attention to women's pubic region (Green, 2005; Rodrigues, 2012; Tiefer, 2008). These physically revealing fashion trends have resulted in the growing popularity of genital grooming – such as Brazilian waxing and permanent laser hair removal – that leaves visible large areas of the vulva that were previously concealed by pubic hair. These trends have intensified "pre-existing negative genital perceptions, self-disgust, and fears of social rejection" (Tiefer, 2008: 467).

Additionally, the 'sexualization of culture'<sup>30</sup> (McNair, 2002) and the culturally ubiquitous sexual imagery in fashion advertising, magazines, television, movies, and pornography, impact this genital 'hyperesthetic' (Braun, 2005a; Gill, 2008b: 39; Green, 2005; Navarro, 2004; Tiefer, 2008: 467). For Weil Davis (2002: 10), the "relative mainstreaming of the sex industry [...] and the blurring of the lines between hard-core

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<sup>30</sup> Also theorized as the following: 'striptease culture' (McNair, 2002), 'porno-chic' or the 'pornographication' of everyday life (McRobbie, 2004; Paul 2005), and the rise of 'raunch' culture (Levy, 2005).

pornography and advertising imagery” pressures women into acquiring and maintaining an appropriately sexualized and airbrushed body, including their genitalia (Whitcomb, 2010). In this context, women’s contemporary sexualized embodiment is best defined as the ‘Barbie Doll’ ideal, which is “characterized by a low BMI, narrow hips, a prominent bust, and *hairless, undefined genitalia resembling those of a prepubescent female*”<sup>31</sup> (emphasis added, Schick et al., 2011: 74). Frueh (2003) connects this ideal of ‘small, dainty labia and tight vaginas’ to the contemporary ‘fitness’ regime and beauty ideals being promoted for women. Frueh (2003: 145) describes this fitness ideal as one in which “the body must be lean and streamlined—‘clean’... Excepting large breasts, it must not exhibit any too-muchness... The clean aesthetic designates looseness and bulges as unsightly generosities of flesh—a mess.”<sup>32</sup> The pervasive cultural ideal for women’s bodies is one that is “slight and unformed...lacking flesh or substance, a body in whose very contours the image of immaturity has been inscribed” (Bartky, 2014: 75). This powerful cultural norm now extends to women’s genitalia, achieved through FGCS.

The hyper-visibility of the vulva and the new ‘absent’ and ‘clean-slit’<sup>33</sup> vaginal ideal – must also be understood as connected to the widespread proliferation and availability of pornography (McDougall, 2013; Rodrigues, 2012). Rodrigues (2012: 791) contends that the hyper-visibility of the vulva in pornography has “enable[d] the

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<sup>31</sup> Contemporary genital ideal has also been referred to as the ‘clean slit’ (Braun & Tiefer, 2010; McDougall, 2013; Weil Davis, 2002).

<sup>32</sup> For further reading, Deborah Caslav Covino’s (2004) book *Amending the Abject Body: Aesthetic Makeovers in Medicine and Culture* explores Julia Kristeva’s theory of abjection and ‘clean and proper bodies’ in relation to how the ‘natural’ female body is mediated as abjected and in need of surgical intervention in order to become socially acceptable.

<sup>33</sup> In the Canadian feminist magazine, *Herizons*, Erica Lenti (2013: 25) notes by referencing Simone Weil Davis’ work that the contemporary fixation on ‘minimalist’ and ‘tidied’ vaginas is largely a Western phenomenon. Some sub-Saharan African women begin to pull their inner labia at puberty, because it is believed to aid in both a woman’s and a man’s sexual pleasure. And in Japan men covet the so-called “butterfly” wings of elongated labia minora (Lenti, 2013: 25).

introduction of an aesthetic dimension into the realm of feminine ‘hygiene,’ [thus] creating new norms according to which bodies must discipline themselves.” However, marketing discourses positively re-conceptualize this notion of ‘discipline’ as “an act of self-care that enables protection or escape from pathologization, ugliness, and sexual disutility and results in entry into sexual representation and expression” (Rodrigues, 2012: 791). Yet, these new norms for female genitalia are most often based on commercial pornographic images of hidden and symmetrical labia minora that have been digitally manipulated through editing software (Koning et al., 2009: 69). These representations can lead women [and men] to believe that the minimalist ‘clean-slit’ is the norm, and for some women to feel as if their genitalia is abnormal (Koning et al., 2009: 69). Koning et al. (2009: 69) argue that this distortion of the norm results in “unnecessary concern and an increase in medical care, all of which is further enforced by increased media attention.” Even when women are made aware of the documented diversity of female genital morphology (Lloyd et al., 2005) or the natural changes that occur over the life course, the ideal promoted by the media nonetheless “carries an implicit message that women should be worried if their genitals do not match up to this exacting ideal” (McDougall, 2013: 774).

Recalling Bramwell et al.’s (2007) study of women who sought out FGCS, they found ‘normality’ to be a repetitive theme in their participants’ recollections of their motivations for undergoing labial reduction surgery. These women often felt that their genital appearance prior to the operation were “‘odd’, ‘weird’ or made them ‘freaks’” (Bramwell et al., 2007: 1495). Frequent references to the ‘abnormal’ aspects of their genitalia denote the existence of a powerful discourse about ‘normal’ genital appearance

(Bramwell et al., 2007). Despite this common feeling of abnormality some women were uncertain about what constituted ‘normal’ labia (Bramwell et al., 2007: 1497).

Contradictorily, for the women in the study who acknowledged the natural variation and diversity in women’s genital appearance, this recognition did not protect them from disliking their genitalia nor from perceiving their labia as ‘abnormal’ (Bramwell et al., 2007: 1495, 1497). In the West, women’s use of the term ‘normal’ in relation to their physical appearance increasingly refers to an unattainable conception of the female form. McDougall (2013: 779) contends that women’s desires to be ‘normal’ are “defined by cultural expectations, [rather than] natural physical attributes.”

In addition to all the factors highlighted above, biomedicine also plays a significant role in redefining what constitutes ‘normal’ physical appearance. According to McDougall (2013: 783), “Medicine has the ability to create new norms and, as a consequence, what was considered natural is no longer necessarily normal.” In this context, as the feminist activist and scholar Tiefer (2008: 471) argues, “the cultural ‘ideal’ becomes the cultural norm and the request for intervention becomes the request to be normal.”

## **Feminist Critiques of the Medicalization of Appearance and Sexuality**

### **Medicalization**

Medicalization is a major intellectual development and conceptual framework emerging in the 20<sup>th</sup> century, and refers to the complex process whereby seemingly nonmedical human behaviours, experiences, and conditions<sup>34</sup> are turned into medical problems, illnesses, and disorders that require biomedical intervention and treatment by

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<sup>34</sup> Tiefer (1994: 365) notes that the common life events that are typically redefined in medical terms are often associated with the physical changes and processes of aging (i.e., baldness, menopause, memory loss, etc.).

medical experts (Cacchioni & Tiefer, 2012; Kohler Riessman, 2010; Polonijo & Carpiano, 2008; Tiefer, 1994). The expansion of medical authority and scrutiny results in various aspects of our contemporary ‘lifestyle[s]’ being continually subsumed under medical dominion, influence, and supervision (Cacchioni & Tiefer, 2012; Tiefer, 2008). Discourses of medicalization result from the perception of culturally ‘abnormal’ or ‘deviant’<sup>35</sup> experiences – which are most often socio-culturally produced and psychologically located (Braun, 2009b: 243; Braun & Tiefer, 2010; Tiefer, 2010). These are progressively dislocated from important contextual social and political factors, which in turn contributes to both biological and psychological reductionism (Tiefer, 2010; Braun, 2009b: 243; Braun & Tiefer, 2010). As the process of medicalization prioritizes the biological at the expense of the social and psychological, nonmedical alternatives or solutions are dismissed and increasingly perceived to be ineffective (Braun, 2009b: 243). Thus, the medical profession has extended its authoritative jurisdiction far beyond its capacity to ‘cure’ these redefined human conditions (Kohler Riessman, 2010).

In order for the process of medicalization to work, Tiefer (1994: 365) claims that, “the particular behavioural area [in question] must be divisible into good (i.e. “healthy” [normal, functional]) and bad (i.e. “sick” [abnormal, dysfunctional]) aspects, and be somehow (albeit often distantly) relatable to norms of biological functioning...[and for] medical technology to have some demonstrable impact on the behaviour.” However, Kohler Riessman (2010: 52-53) contends that there does not need to be a biological basis for an experience to be defined in terms of illness, because our concept of ‘illness’ itself is socially constructed. Kohler Riessman (2010: 49) suggests that the process of

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<sup>35</sup> Abnormal or deviant behavior often refers to a societally perceived sin, crime, or antisocial act, which may change over time (Tiefer, 1994).

medicalization is always political, meaning that the views of medical professionals often eclipse other understandings of embodiment. Through this process, “medical practice becomes a vehicle for eliminating or controlling problematic experiences that are defined as deviant [or abnormal], for the purpose of securing adherence to social norms” (Kohler Riessman, 2010: 51). Some examples of human behaviours that have historically been classified as ‘deviant’ or ‘abnormal,’ include menopause, alcoholism, opiate addiction, and homosexuality: in short, where once these behaviours were categorized as ‘bad’; more recently they are classified as ‘sick’<sup>36</sup> (Kohler Riessman, 2010: 51). The process of medicalization reveals that the practice of medicine is not merely a scientific enterprise but rather also a social one (Kohler Riessman, 2010: 53).

### **The Shifting Commercial Nature of Medicine**

Historically, medicine was focused on providing treatment and cures for physical health issues and arguably continues to prioritize the treatment of physical ailments and diseases (McDougall, 2013: 784). However, in recent years a new medical paradigm has surfaced, as there has been a notable shift in Western practice to tackle ‘quality of life issues’ and ‘the pursuit of happiness,’ concepts that are difficult to define, let alone effectively treat (McDougall, 2013: 784). With this re-orientation of medical treatment, intervention, and management, a consumer medical model has emerged. The emergence of this new medical paradigm has created profitable economic incentives for a range of health professionals to develop new problems, exacerbate bodily insecurities, and

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<sup>36</sup> There are both positive and negative social consequences in re-labelling previously criminalized behaviours into medical problems. The process of medicalization has the potential to result in “greater humanitarianism, tolerance, and other benefits associated with ‘progress’” (Kohler Riessman, 2010: 52). Meanwhile, it can also increase the stigma of certain behaviours when they are labelled an ‘illness,’ which can create or reinforce previous conceptions of ‘deviance’ (Kohler Riessman, 2010: 52).



redefine optimal human functioning, as they simultaneously offer innovative medical solutions for profit (McDougall, 2013: 784). Cacchioni and Tiefer (2012: 308) contend that the term *biomedicalization* (Clarke et al., 2003) aptly captures the increasing technological and commercial nature of contemporary medicalization processes. Other theorists have coined the terms *healthism* or *healthicization* to refer to medicalization's expansion into concerns of risk management through health promotion, surveillance, and scrutiny (Cacchioni & Tiefer, 2012: 308). Echoing Kohler Riessman's observations, McDougall (2013: 785) suggests that, "this new medical model releases medicine from its rigid scientific underpinnings, and exposes the practice of medicine as an increasingly cultural and commercial pursuit, one that has important implications for women, and for men." For Cacchioni and Tiefer (2012: 308), these shifting medical discourses reaffirm the centrality of these concepts to our everyday experiences, including our sex lives.

Feminist scholars have become increasingly concerned about the role biomedicine plays in shaping societal perceptions of normality, and the growing conflation of 'treatment' with 'enhancement', especially as capitalism and medicine have become increasingly intertwined (McDougall, 2013: 783; Tiefer, 2008: 471). Advanced capitalism depends on the creation of new markets, needs, and desires (McDougall, 2013: 783). In this context healthcare services and needs have been targeted for their profit-making potential. Through the conjoined processes of medicalization and capitalism, the market and medical industry have expanded "the realm of pathology constructed in women that medical intervention alone can treat" (Gillespie, 1996: 77).

Research into elective aesthetic surgery, particularly FGCS, can showcase the extent to which the field of medicine has changed as cosmetic surgeons embrace this new

consumer-driven medical model (McDougall, 2013). McDougall (2013: 70) argues that cosmetic surgeons' vested economic interests in the medicalization of appearance has resulted in the 'commodification of cosmetic surgery,' which has "led to the medicalization of female shape and appearance in ways that...[reproduce] normalizing discourses on women's bodies that...negate women's natural diversity and difference." McDougall (2013: 783) also notes that the cosmetic surgery industry perpetuates and profits from "the fragmentation of the body," the process by which parts of the body are fetishized, isolated for aesthetic critique, and subjected to the whims of market forces and the possibility of surgical 'correction' or 'enhancement.' The fragmentation of the body distorts our embodied experiences and relationship with our bodies, because it reduces our bodies to a collection of 'features' similar to those of other merchandised products, making various parts of our bodies continually upgradable (McDougall, 2013: 783). I suggest that the development of the FGCS industry, which exclusively targets women's genitalia for surgical 'correction' and 'enhancement', is an example of this practice at work. Women's genitalia have become another commodified part of their bodies.

### **Issues with the Medicalization of Sex**

The *Journal of Sex Research* released a special issue (2012) on the medicalization of sex, focusing its critical lens on the impacts of medicalization on all areas of sexual life with the aim of contextualizing and expanding upon the historical and sociocultural aspects of sex for the sexological community and the broad field of sexuality studies (Cacchioni & Tiefer, 2012: 307). In the editorial for this issue, Thea Cacchioni and Leonore Tiefer (2012: 309) highlight that the majority of research addressing the medicalization of sex has criticized, "the genitalization of sexuality (and its inadvertent

androcentrism), the standardization of sexuality (accompanied by new forms of shame), neglect of psychosocial elements (how these factors shape sexual enjoyment, well being, identities, practices, and norms), and...the iatrogenic health risks and side effects of both off-label and approved medical treatments.” Tiefer’s (2010: 199) previous work on this topic suggests that the process of medicalization reinforces a narrow definition of sexual normalcy, which makes women of all ages more sexually insecure, while the educational efforts to offset sexual insecurities are undermined in favour of quick medical fixes. She (2010: 199) further notes that the medicalization of sexuality means that, “the media will continue to ignore social factors that make both women and men anxious about sexuality and vulnerable to developing sexual problems.” Overall, these authors argue that the increasing medicalization of sexuality in the West imposes limits on sexual diversity and sexual expression through the commercialized pursuit of profits over pleasures and the creation of new forms of medical surveillance and control—all of which are highly applicable to the FGCS industry (Cacchioni & Tiefer, 2012: 307).

### **Women – The Main Targets of Medicalization**

Feminist health researchers and activists have noted since the early 1970s that women have been the main targets of medicalization, specifically women’s reproductive organs and their associated functions and/or changing functions related to the natural processes of aging (i.e. menstruation, fertility/conception, pregnancy, childbearing, and menopause) (Cacchioni & Tiefer, 2012: 308; Kohler Riessman, 2010: 50; Parker, 2010: 45). It is not surprising that both the narrow aesthetic norms of the external female genitalia and the perceived ‘diminished’ or ‘damaged’ sexual functioning of postpartum vaginas have been recently declared legitimate areas for medical intervention and

treatment under the guise of expanding medical discourses concerned with enhancing women's sexual attractiveness and pleasure.

Kohler Riessman (2010) covers four reasons why women are subject to more medical definitions, scrutiny, and control than men. Firstly, she (2010: 61) acknowledges that the markers of women's biological processes (i.e. menstruation, pregnancy, childbirth, lactation, etc.) align nicely with medicine's biomedical orientation, whereas men's are more concealed within the body and are seldomly treated as being pathological<sup>37</sup> (Parker, 2010: 45). Second, women's normative role as primary caregiver for children and elderly relatives places them in contact with the medical system (Cacchioni & Tiefer, 2012: 308; Kohler Riessman, 2010: 61 – 62). Third, women make more visits to their physicians' offices than do men, although it remains unclear why. Explanations for this phenomenon range from the medicalization of their biological functions, the perception of women having "real" illnesses, differences in gendered behaviour norms when ill, or simply Western cultural expectations (Kohler Riessman, 2010: 62). Whatever the cause for this behaviour, one result is that women are more exposed to medical labeling and practices, which may make them more susceptible to experiencing their bodily processes and functions in predominantly or exclusively medical terms (Kohler Riessman, 2010: 62).

Finally, women's structural subordination to men is the last reason for the disproportionate medicalization of women's lives (Kohler Riessman, 2010: 62). This position connects with previous feminist research that drew attention to the ways in which medicine is intimately related to women's unequal social position (Gillespie,

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<sup>37</sup> With the relatively recent exception of impotence or 'erectile dysfunction' after the introduction of Viagra in 1998.

1996). For example, in the male-dominated domain of medicine, female patients are more likely to encounter and be treated by male physicians<sup>38</sup> (Parker, 2010: 46). This interaction can reproduce broader patriarchal relations, though they are masked by ‘science’ (Kohler Riessman, 2010: 62). Therefore, the ‘medical gaze’ of physicians remains an androcentric ‘male gaze’, which can have adverse consequences for women’s embodied experiences of health, illness, and disease (Cacchioni & Tiefer, 2012: 308; Parker, 2010: 46). Further, feminist medical scholars have linked the lack of women in medical practice (especially during the foundational years of modern Western medicine) to the ongoing authority and dominance of “negative and dismissive attitudes toward women’s bodies in medical discourse and education” (Cacchioni & Tiefer, 2012: 308). Some feminist scholars have argued that the historically religious justifications for patriarchy have shifted towards the scientific (Ehrenreich & English, 1979 in Kohler Riessman, 2010), while other feminist scholars have asserted that, “medicine is the scientific equivalent of earlier customs like marriage laws and kinship rituals that controlled women by controlling their sexuality” (Kohler Riessman, 2010: 62). This patriarchal control over women’s bodies is most strikingly obvious when male physicians dictate appropriate sexual conduct to young women by lecturing them about the dangers of promiscuous sexual behaviour, or by purposefully withholding contraceptive information (Kohler Riessman, 2010: 62). The reasons offered by Kohler Riessman (2010) suggest women are the ideal patient and market for the expansion of medicine, as

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<sup>38</sup> In Scully and Bart’s (1973) article, which examined American gynaecological textbooks, they noted that gynaecologists at that time were overwhelmingly male (93.4%). Through a sociological lens, they acknowledge that, “one’s perspectives are constrained by one’s place in the social structure and thus gynecologists may not adequately represent the worldview and the interests of the group they are supposed to attend and advocate” (Scully & Bart, 1973: 1045). This arguably has significant and potentially negative repercussions for women’s reproductive care and health.

they are more likely to reliably consume prescribed health practices, advice, and medical treatments, thus ensuring physicians will consistently have a treatable and receptive pool of patients (Kohler Riessman, 2010: 62). Overall then, the increasing medicalization of women's experiences secures the continuation of prevailing social interests and patriarchal institutions (Kohler Riessman, 2010: 62).

However, Kohler Riessman (2010) warns against simply interpreting this process as a conspiratorial attempt by male physicians and the 'medical industrial complex' to subordinate women. Such an analysis is incomplete, as it ignores the contemporary workings of power theorized by Foucault and fails to recognize that certain groups of women have willingly and actively participated in the medicalization of particular female experiences (Kohler Riessman, 2010: 62). Nevertheless, this analysis does aid women's health activists in shifting women's consciousness and understanding about their health by addressing the sexual politics that are interwoven into social conceptions of illness, as well as our beliefs about treatment (Kohler Riessman, 2010). The point of this analysis is to help women reclaim knowledge about and control over their bodies (Kohler Riessman, 2010).

### **Medicalization & Women's Active Collaboration**

Kohler Riessman's (2010: 51) critique of medicalization expands on previous feminist analyses, as she explicitly acknowledges women's contributions to redefining certain gynocentric-embodied experiences into 'treatable' medical categories. Kohler Riessman (2010) contends physicians are motivated by specific ideological beliefs and have vested economic interests that are connected to the advancement of the profession and consequently, physicians will respond to market conditions that serve their interests

(Parker, 2010: 47). In contrast, women's participation in the medicalization process is linked to "their own needs and motives, which in turn grow out of the class-specific nature of their subordination" (Kohler Riessman, 2010: 51). Kohler Riessman (2010: 50) suggests it is important for feminist analyses to acknowledge and address women's active participation in the construction of new medical definitions and treatments. This is because, by not recognizing the reciprocal nature of this process, she (2010: 51) argues women are cast as passive victims of medical ascendancy, and this perpetuates the very kinds of assumptions about women that feminists have been trying to challenge. Ultimately, Kohler Riessman's (2010: 60) work illuminates the following point about medical social control:

There are times when the interests of women from the middle and upper classes are served by the therapeutic professions, whose political and economic interests are in turn served by transforming these women's complaints into illnesses. In other words, both historically and currently, there has tended to be a "fit" between medicine's interest in expanding its jurisdiction and the need of women to have their experiences acknowledged.

However, she (2010: 63) does acknowledge that the medicalization of women's bodily functions has resulted in a contradictory and paradoxical reality for women, because:

As women have tried to free themselves from the control that biological processes have had over their lives, they simultaneously have strengthened the control of a biomedical view of their experience. As women visit doctors and get symptom relief, the social causes of their problems are ignored. As doctors acknowledge women's experience and treat their problems medically, problems are stripped of their political content and popular movements are taken over.

I draw on these debates in my analysis of FGCS to better understand how and when women seek surgical interventions for relief of genital distress, and the socio-cultural factors that influence a woman's perceptions that her genitalia are abnormal. I suggest that the medicalization of genital appearance further legitimates the practice of FGCS as

a valuable solution, while simultaneously undermining non-medical alternatives and remedies. As such, it is crucial that medical scholars acknowledge that this collaboration between women and the medical community has been riddled with tension and challenges for women. Indeed, women have both gained and lost significant autonomy with each medical intrusion into their lives (Kohler Riessman, 2010: 50, 60).

Feminist critiques of medicalization, medical discourse, and biomedical authority claim these processes are implicated in the maintenance of women's unequal social position (Gillespie, 1996). For example, the contemporary shift towards a new consumer medical-model and the rise in the medicalization of appearance and sex has created new medical 'conditions', which arguably disproportionately target women (McDougall, 2013). A significant concern in relation to the practice of FGCS is that the medicalization of women's genital appearance has created a 'new worry' for women amplifying their pre-existing genital anxieties, and promoting cosmetic surgery as the only viable solution to alleviating this distress (Braun & Tiefer, 2010: 6). Therefore, the practice of medicalization promotes FGCS, whilst it simultaneously undermines alternative and non-surgical treatments to mediate genital distress (Braun & Tiefer, 2010: 6). Ultimately, once women's [and men's] problems are shrouded in medical language, they are removed from public discussion and debate, while medicine attempts to tackle issues that are fundamentally social in origin (Kohler Riessman, 2010: 52). By wholly reframing the issue of women's genital distress in terms of biological and personal deficits, medicine "naturalises, normalizes and individualises the experience of genital distress for women, locating the problems she perceives as an almost inevitable response to unappealing physiology" (Braun & Tiefer, 2010: 6).



## **Why Accurate and Diverse Representations are Important to Women's Sexual Health**

The media's representation of women's genitalia and their influence on women's genital perceptions are important areas of study. This is especially the case as researchers suggest negative and misogynistic socio-cultural representations of the vagina and vulva contribute to some women's feelings of genital anxiety and their subsequent desire to undergo 'corrective' FGCS procedures (Bramwell, 2002; Braun, 2005a; Braun & Wilkinson, 2001; Green, 2005; Lloyd et al., 2005; NVC, 2011; Tiefer, 2008). The impact mass media and advertising has on women's general body image and self-esteem has been extensively studied. Previous research has found that media depictions influence women's conceptions of feminine beauty ideals, body image, and appearance norms, as well as their ideas about health, illness, and sexuality (Bordo, 1993; Braun, 2005b; Carpiano, 2001; Schick et al., 2011; Sullivan, 2001). Furthermore, mass media has been linked to influencing women's decisions about elective cosmetic procedures (Blum, 2003; Braun, 2005b; Hennink-Kaminski et al., 2010), and has additionally been described as the 'gold standard' against which women self-evaluate and compare their bodies (Schick et al., 2011: 74). Therefore, the existing literature strongly suggests that mass media representations of women's bodies and genitalia—which I argue include content from Canadian FGCS provider websites—have repercussions for women's sexual and reproductive health and well-being (Braun & Wilkinson, 2001: 26).

### **Women's Body Image and Genital Self-image**

Researchers, who have studied women's exposure to idealized depictions of the female form and appearance that are not representative of population norms, found that women's body image satisfaction decreased (Schick et al., 2011: 81). Indeed, the

destructive impact of exposure to idealized media images and representations on women's satisfaction with their body and overall appearance has been thoroughly documented (Schick et al., 2011: 74). Previous studies on women's body image have manipulated the duration of women's exposure to various media images portraying the contemporary thin ideal. These studies established a link between women's media exposure and body dissatisfaction, and suggest, "women may be vulnerable to the harmful effects of media exposure irrespective of their physical appearance or tendency to self-objectify" (Schick et al., 2011: 74). Besides fostering poor body image in women, extended media exposure has also been shown to pose significant risks to women's physical and mental health (i.e., depression and disordered eating symptomatology) (Schick et al., 2011: 74). Schick et al. (2011: 75, 81) acknowledge that further research is needed to determine whether similar exposure to sexually explicit media images, such as mainstream pornography, negatively impacts women's perceptions of their genital appearance. Additionally, I suggest more research needs to be done to determine the impact of representations of female genitalia from FGCS provider websites on women and their genital self-image and sexual esteem.

Howarth et al. (2010) address this gap in the literature concerning genital morphology and individual perceptions. They (2010: 78) stress scholars need to commit to researching, "the psychosocial processes and influences that shape (a) an individual's ideas about average and acceptable genital morphology and (b) the decision-making process to seek medical advice or intervention for their own appearance." Miklos and Moore (2008: 1494) recommend more research be conducted to establish whether there exists a relationship between women's genital self-image and their sexual function,

because one's genital self-image is arguably important for understanding women's sexual confidence and function, yet it is not explicitly acknowledged or assessed in much of the literature on body image and sexual function. Miklos and Moore (2008: 1494) assert that, "it is easy to understand how many women might feel sexually inhibited if they are not comfortable with the appearance of their vagina, vulva, or external genitalia." Therefore, the impacts of women's genital self-perceptions on their sex lives, in terms of sexual expression, pleasure, health, and function warrants further investigation.

Ackard et al. (2000: 423) conducted a survey to determine whether a woman's overall self-image and body image were significant predictors of sexual activity. Their study was based on previous research, which suggests that, "body image concerns can influence comfort during sexual activity, which presumably influences sexual enjoyment...[and] intense body dissatisfaction may result in avoidance of sexual activity because of self-consciousness." They found that women with a positive body image compared to those dissatisfied with their body image, report having "sex more frequently, achieving orgasm during sex more frequently, faking an orgasm less often, initiating sex more often, and experiencing greater comfort undressing in front of their partner, greater comfort having sex with the lights on, greater comfort trying new sexual activities, and greater confidence in their ability to give their partner sexual pleasure" (Ackard et al., 2000: 425). Although this study does not explicitly reference women's genital self-perception, it nevertheless confirms that a woman's overall body image is an important predictor of one's comfort with sexual behaviour and the frequency in which one engages in sexual activity (Ackard et al., 2000: 428).

Herbenick et al. (2011) recognize the importance of studying women's genital perceptions and genital self-image. They used the Female Genital Self-Image Scale (FGSIS-4)—a 4-item measure—to assess female genital self-image and its impact on sexual and health behaviours. Previous research indicates that, “female genital self-image is related to women's engagement in sexual behaviors such as vibrator use and receptive cunnilingus, in addition to sexual function” (Herbenick et al., 2011: 159). In their survey, they found that, “female genital self-image was significantly related to female sexual function, women's sexual behavior and their sexual and genital healthcare behaviors”<sup>39</sup> (Herbenick et al., 2011: 158). Herbenick et al. (2011: 164) suggest, “that women's feelings and beliefs about their genitals may be related to their comfort or willingness to participate in behaviors that provide close contact with or viewing of their genitals.” These findings stress how detrimental a woman's negative genital self-image can be for her sexual health and sexual satisfaction and fulfillment. They also highlight the importance of sex education and media images which represent the range of ‘normal’ forms of genital embodiment to challenge feelings of genital self-disgust, embarrassment, and dissatisfaction.

In this context, *The New View Campaign*<sup>40</sup> maintains that the most potent forms of resistance against corporate biomedical definitions of genital appearance norms and sexual problems are through public ‘consciousness-raising’ initiatives (Tiefer, 2006: 371). The campaign asserts that the mixture of poor sex education and conservative moral

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<sup>39</sup> Further findings in the study found that women's scores on the FGSIS-4 scale were also correlated with: “their frequency of masturbation, having had a gynecological exam in the past year, having performed a genital self examination in the previous month, and having used a vibrator in the past month” (Herbenick, et al., 2011: 164)

<sup>40</sup> Dr. Leonore Tiefer and various feminist social scientists and clinicians founded *The New View Campaign* in the summer of 2000 in New York City as a grassroots feminist response to the pharmaceutical industry's growing influence on the field of sexology (Tiefer, 2010: 199). They began to investigate the FGCS industry in 2006.

contests involved in public discourse about sexual pleasure create a vulnerable public (Tiefer, 2010: 57; Tiefer, 2008: 453). Furthermore, the standardization of sexuality through the biomedical model is accompanied by new forms of shame, which are exploited for profit on FGCS provider websites (Cacchioni & Tiefer, 2012: 309). Overall, *The New View Campaign* attempts to address the shame and ‘pudendal disgust’ that shape many women’s perceptions of their vulva and to challenge the ever-increasing patriarchal scrutiny of female bodies that is achieved in part through these FGCS provider websites, insofar as they contribute to increasing levels of debilitating body hatred (Tiefer, 2008: 475). Indeed, girls and women in the 21<sup>st</sup> century require self-confidence to resist misinformation—which runs rampant throughout FGCS provider websites—and *The New View Campaign* is attempting to spark “a nationwide movement to celebrate depictions of true-to-life female genital diversity” (NVC, 2011). I agree with *The New View Campaign*’s assertion that girls and women need better information about sexual health and pleasure in order to feel comfortable with sex and intimacy and to be proactive about their health (NVC, 2011).

## **Chapter 5 - Methods of Data Collection**

### **Introduction**

In order to develop an understanding of the heteronormative and feminine discourses that are produced, sustained, and negotiated through representations on Canadian FGCS clinics' websites, I have employed a qualitative Critical Discourse Analysis (CDA) that is situated within a feminist-informed social constructionist framework (Lazar, 2007).

Critical Discourse Analysis (CDA) aligns well with my topic of investigation and social justice scholarship because it aims to expose the complex workings of social inequalities through language and visual iconography. According to Lazar (2007: 145), "CDA is part of an emancipatory critical social science which...is openly committed to the achievement of a just social order through a critique of discourse." There exist a multitude of definitions and meanings for the term discourse. However, I rely on Sara Mills' (2004) approach to understanding discourse. She (2004: 15) suggests that we:

...not [think of discourse] as a group of signs or a stretch of text, but as 'practices that systematically form objects of which they speak'...in this sense, a discourse is something which produces something else (an utterance, a concept, an effect), rather than something which exists in and of itself and which can be analysed in isolation.

In this study I will use of Critical Discourse Analysis to explore how, and in what ways, FGCS websites might rely on and reproduce heteronormative sexual discourses which impose restrictive models of femininity through the pathologization of genital diversity and the appropriation of post-feminist and neoliberal discourses of individual choice and empowerment.

## **Data Collection & Sampling Strategy**

Over the 2012-2013 academic year, I conducted several searches of FGCS provider websites using a variety of FGCS related terminology, such as labiaplasty, vaginoplasty, hymenoplasty, in combination with varying Canadian geographic locations to ensure the widest possible capture of Canadian-based FGCS provider websites. I used the search engine Google to obtain my data set, because it has been consistently ranked as the best and most widely used search engine (Liao et al., 2012; Rufai & Davis, 2014). Therefore, by using Google, I am likely imitating the Internet search patterns of the average Canadian consumer engaging in online consumer research about FGCS. My initial data set consisted of 35 websites, with the vast majority located in Toronto, Ontario. My preliminary data set was by no means an exhaustive list of all the Canadian clinics providing FGCS procedures, because some surgeons will not advertise these procedures online due to their controversial nature (Montreal Gazette, 2008). In order to make my data set more manageable, I decided to use only 10 of the websites from my preliminary data set. I included provider websites that advertised the two main FGCS procedures (labiaplasty and vaginoplasty) and/or had extensive visual and textual data to analyze. This ensured the websites I was working with had the most comprehensive information and images related to the two most popular FGCS procedures. The websites in my dataset were professionally maintained and regularly updated with the majority of them offering the full range of bodily enhancement and cosmetic procedures, therefore, I restricted my analysis to the relevant sections devoted exclusively to FGCS, which typically consisted of several pages of content per site. My study did not require ethical

approval, because the data pulled from these provider websites exists in the public domain and is commonly available.

For my analysis, I screen shot and catalogued the relevant material on the websites and examined this material for repetitive language, messages, and visuals. I paid special attention to: (1) the use of patient testimonials and surgeons' purported claims and endorsements of FGCS; (2) whether or not the websites adequately outline the associated risks of FGCS procedures (i.e., downplay risks, while over emphasizing purported benefits versus providing a balanced discussion of both the benefits and the risks); (3) the presence or omission of before and after images for FGCS procedures, especially if an image gallery is accessible online and showcases the outcomes of other cosmetic procedures; and (4) whether the Canadian websites reproduced the discourses present in Braun's (2009a) and Moran and Lee's (2013) CDA analyses of American and Australian FGCS provider websites, specifically, the types of subjectivity, femininity, agency, bodies and embodiment that are privileged in these accounts.

### **List of 10 Canadian FGCS Websites**

#### **Alberta:**

1. ***The Allan Centre for Women*** located in Calgary, Alberta performs Laser Vaginal Rejuvenation®, which is described as improving “the overall appearance of the vagina and enhances muscle tone, strength and control, which can give a woman a more satisfying sex life” (Allan Centre for Women, 2009).

<http://www.allancentreforwomen.com/>

#### **British Columbia:**

2. ***The NewWoman™ Canada*** clinic run by Dr. David Wilkie specializes in gynecological surgery and care, offering cosmetic reconstructive and aesthetic vaginal surgery. The clinic specializes in vaginal rejuvenation, labiaplasty, and perineoplasty. The office is based in Vancouver, British Columbia and declares they have been providing “surgical excellence for over 20 years” (NewWoman, 2013).



<http://www.newwoman.ca/about-newwoman>

3. ***False Creek Healthcare Centre*** is based in Vancouver, Canada and on its main webpage has a tab to cosmetic gynaecology, which leads to a page outlining labiaplasty, vaginoplasty, pubic liposuction, and clitoral repositioning procedures. Dr. Roy Jackson is the cosmetic surgeon who specializes in these procedures. Jackson's biography on the website states that he intends to "empower women by providing choice, knowledge and health alternatives" (False Creek, 2013).

<http://www.falsecreekplasticsurgery.com/>

#### **Manitoba:**

4. ***The First Glance Aesthetic Clinic and Surgery Centre*** offers the following cosmetic gynaecology procedures from their Winnipeg clinic: hymenoplasty, labiaplasty, and Laser Vaginal Rejuvenation®. Dr. Anthony P. Lockwood is a Canadian Board Certified Plastic Surgeon who specializes in laser surgery. He has been practicing cosmetic surgery in Winnipeg, Manitoba since 1989 and has many years of experience and expertise in gynaecology. Dr. David Matlock trained Dr. Lockwood at the Laser Vaginal Rejuvenation Institute of America in Laser Vaginal Rejuvenation (LVR) and Designer Laser Vaginoplasty (DLV). The clinic prides itself on its ability to "help you feel more like the woman you know you are" (First Glance, 2013).

<http://thefirstglance.ca/>

#### **Ontario:**

5. ***Toronto Cosmetic Clinic (TCC)*** offers a wide range of FGCS procedures at their North York clinic: Designer Laser Vaginoplasty® (DLV®), Laser Vaginal Rejuvenation®, G Shot® Injections, Clitoral/Prepuce Reduction (De-hooding), Vaginal Tightening, Hymen Restoration (Hymenoplasty). The webpage on Labiaplasty calls for women to "Embrace Your Beauty" and to "Finally Feel Comfortable With Yourself" (TCC, 2015), as they offer a variety of labia reduction procedures, such as the Barbie Labiaplasty, the Rim or "Peek-a-boo" Labiaplasty, the Hybrid Labiaplasty, and the Labia MAJORA-plasty. These procedures are all performed by Dr. Dimitrios Giannoulas, the clinic's consultant gynecological specialist. He was the first physician in Ontario to be certified by the Laser Vaginal Rejuvenation Institute of America (TCC, 2015). Dr. Giannoulas' online biography notes he graduated from the University of Toronto in 1982 and completed his residency in Obstetrics and Gynaecology (TCC, 2015).

<http://www.tcclinic.com/>

6. ***The Plastic Surgery Clinic*** located in Mississauga/Toronto provides vaginal tightening, labia reduction, and hymen repair surgeries. Dr. Lista and Dr. Ahmad, the two surgeons who perform the FGCS procedures at the clinic endorse a 'patient-centred approach' and claim that they are both "dedicated to treating their labia reduction patients

with dignity to ensure they feel safe and comfortable with the delicate nature of this surgery” (Plastic Surgery Clinic). The website indicates that the clinic performs around 150 – 200 labial reduction procedures per year.

<http://www.theplasticsurgeryclinic.com/>

7. **Toronto Cosmetic Surgery Institute** performs a wide range of cosmetic procedures, including vaginal rejuvenation, labiaplasty and hymenoplasty, and mons pubis liposuction. Dr. Martin Jugenburg performs the FGCS procedures and is presented as having “the education, surgical finesse, and experience to ensure you get world-class surgical care, and the best possible aesthetic result” (Toronto Cosmetic Surgery Institute).

<http://torontosurgery.com/>

8. **Clinic 360** (Toronto) offers an extensive range of FGCS options, including vaginoplasty, labiaplasty, hymenoplasty, clitoral unhooding, perineoplasty, vaginal rejuvenation, non-surgical vaginoplasty, and urinary incontinence. Again these procedures are mostly performed by Dr. Dimitrios Giannoulis, who is also the main FGCS surgeon at the Toronto Cosmetic Clinic.

<http://www.clinic360.com/>

9. **Meridia Medical Group** (Toronto) was included for its extensive material on labiaplasty despite the fact that the clinic does not advertise vaginoplasty. David Gerber is the gynaecologist who owns and runs the clinic and promotes his guiding medical philosophy—the ‘Feminine Ethics of Care.’

<http://www.meridiamedical.com/>

10. **Edelstein Cosmetic** (Toronto) only offers labiaplasty for vaginal cosmetic operations but I included this website for its detailed coverage of this procedure, as well as for its before and after gallery. In addition, women have the option of choosing between a more traditional labial genital appearance and that of the ‘Barbie,’ which is the complete removal of the inner labia. The labiaplasty procedures are performed by Dr. Jerome Edelstein.

<https://www.edelsteincosmetic.com/>

### **Rational for Examining FGCS Marketing on Provider Websites**

I chose to analyze FGCS provider websites because cosmetic surgeons typically work out of private clinics and market their services to ensure a continued source of revenue, as the majority of cosmetic procedures are elective, or not medically necessary.

Advertising cosmetic surgery directly to the public then has become an important tool in recruiting new patients (Ahn et al., 2013: 98), and one of the best mediums of direct-to-consumer advertising is the Internet where FGCS advertisements have become widespread (Blackwell, 2014; Braun, 2005a; Liao et al., 2010: 22; Liao et al., 2012: 1). Further, competition between surgeons has intensified in recent years as the supply of plastic surgeons entering into private practice has outpaced the growth of surgical demand by patients (Hennink-Kaminski, 2006 in Ahn et al., 2013: 98), thus highlighting the important role advertising plays in providing a steady rotation of new patients for cosmetic surgeons.

Previous research has shown that people rely on the Internet as a source for a wide range of health and medical related information (Hardey, 1999; Moran & Lee, 2013: 3). According to Crouch et al. (2011), women and girls searching for surgical solutions to alter their labia's appearance report having visited such sites in an effort to seek out information on the various procedures available (Liao et al., 2012: 1). The importance of website advertising for those seeking out medical and cosmetic information can be seen through research that demonstrates that over a 5-year span (2002 to 2007), FGCS surgeons' monthly website traffic was found to have rose from 8000 monthly visits to an average of 40,500 visits (Kolb, 2010: para. 2). In addition, according to a recent *National Post* article "female genital surgery has become so popular it is now one of the most Google-searched forms of cosmetic surgery" (Kirkey, 2014). A study conducted by Koning et al. (2009: 67) also concluded that "participants who used the Internet as an information source for labia minora reduction considered...[this surgery] more frequently, compared with participants who had other sources of information."

Further, they found that “participants using the Internet as an information source about labia minora reduction [were] in greater agreement that labia minor reduction is an acceptable procedure than participants who use another information source” (Koning et al., 2009: 70).

There are few enforceable regulations and consumer safeguards in the field of cosmetic gynaecology and medical marketing. The bioethics of FGCS marketing remain controversial and troubling, especially because the “aggressive marketing has increased demand for these procedures” (Braun, 2010: 1401) and enable them to flourish despite a complete lack of evidence that these procedures enhance sexual pleasure or functioning (Braun, 2010: 1401). As other researchers have noted, the information presented on many of these sites tends to exaggerate false or unproven claims, while downplaying the associated risks of surgery to the genital area (Heyes, 2007 as quoted in Tiefer, 2008: 470). In addition, Tiefer (2008: 471) notes that FGCS “enhancement technologies are usually marketed and sold by taking advantage of a person’s perception that she is deficient in some way.” Therefore, some scholars argue that these websites’ efforts at ‘educating’ the public, and in particular women “about the surgical solutions to potentially unknown defects in their bodies” (Liao et al., 2012: 5), have more to do with shaping women’s genital expectations in order to create dissatisfaction and a profitable market (Tiefer, 2008: 473) than with a genuine concern for women’s genital anxieties. Given cosmetic surgeons’ blatant conflict of interest, the FGCS industry and their advertising techniques warrant critical scrutiny.

While these concerns highlight the importance of research in this area, Liao, et al. (2012: 2) maintain that there has not been much academic interest in “the information

contained in medical provider advertisements for FGCS.” Even more broadly, there have been relatively few studies that critically examine the communication styles of cosmetic surgery websites (Ahn et al., 2013: 98). Through my own research of the existing literature I was able to confirm only a handful of articles that analyzed the content of FGCS surgeons’ websites (Braun, 2010; Liao et al., 2012; Moran & Lee, 2012); and none of them focused exclusively on Canadian FGCS surgeons’ websites. My research will address this gap in the literature with a specific focus on Canadian surgeon websites. I hope this work will contribute to better understandings of the information and marketing strategies surgeons use through their websites to increase demand of FGCS procedures in Canada.

## **Chapter 6 – Findings of Website Analysis & Discussion**

### **Introduction**

My analysis of 10 Canadian FGCS provider websites reveals several predominant discourses that organized the online material: the pathologization of genital diversity; restrictive models of femininity; heteronormative sexual scripts; and neoliberal and post-feminist rhetorics of individual choice and empowerment. In addition, I found that provider websites represent FGCS as psychologically and sexually transformative, in order to depict FGCS as a rational and reasonable solution to genital distress. Overall, these discourses work together to de-legitimize women's genital diversity, while framing FGCS as the only viable solution to alleviate women's perceptions of genital and sexual distress.

I analyze the ways in which the FGCS websites:

- (1) undermines female genital diversity;
- (2) pathologizes 'hypertrophic labia';
- (3) medicalizes vaginal laxity/relaxation which affirms normative heterosexuality;
- (4) validates neoliberal and post-feminist rhetoric of individual choice and empowerment that undermine criticism of FGCS;
- (5) promotes FGCS as psychologically and sexually transformative.

In the following section I discuss each discourse and its social effect in turn.

### **FGCS Constructs Narrow Genital Representations for Women**

As previously mentioned, the growth of the hairless pubic norm has made vulvas increasingly visible to women and their partners, and has aggravated some women's negative genital self perceptions, which can result in feelings of self-disgust, shame, and

fears of social rejection (Tiefer, 2008: 467). *The New View Campaign* argues women are “bombarded with messages that induce anxiety, insecurity and unrealistic expectations about their bodies, and that the representations of women’s vulvas that are available to the public do little to instill feelings that differently shaped, colored, sized and aged genitalia are OK just as they are” (NVC, 2011). Additionally, Leonore Tiefer acknowledges that women cannot develop or sustain positive attitudes about their genitalia if they are continually exposed to images of vulvas that are post-operative and airbrushed, or belong to hairless cartoon stick figures (NVC, 2011).

The 10 websites I examined do nothing to ease or dispel women’s genital insecurities, but rather exploit the very anxieties they purport to treat. In particular, websites’ visual depictions (see Appendix A) and linguistic descriptions of women’s genitalia portray an extremely specific and narrow range of acceptable genital appearance and function for women. The Canadian FGCS provider websites all represent ‘normal’ or ‘idealized’ female genitalia as small, neat, symmetrical and contained, which Weil Davis (2002) refers to as the ‘clean slit.’ For example, the Meridia Medical Group website provides four images of vulvas that they claim exemplify a ‘normal’ vulva appearance in two separate locations on their website, although they use the same images. The vulvas shown were all completely bare with no pubic hair or skin irritation, and with smooth and flattened labia majora (see page 150, Appendix A). The labia minora in two of the four images appear almost unnoticeable and indistinct from the vaginal opening. The other two images show labia minora that are slightly flared as they descend down from the clitoral prepuce (hood) above, yet they nonetheless remain inconspicuous and unobtrusive. The website of the Meridia Medical Group also includes 17 patient ‘before

and after’ photos in their labiaplasty gallery—the most extensive vulva gallery of any of the six FGCS provider websites that included such galleries of their procedures (see page 152, Appendix A). The post-operative images in these galleries resemble the minimalist labial minora and vulval appearance showcased in the Meridia Medical Group’s ‘normal’ vulva appearance gallery described above, whereas many of the pre-operative images appear to exaggerate or emphasize the length of the ‘elongated’ labia minora by stretching them outwards away from the vaginal opening, rather than having the labia minora rest more naturally in the photos.

The visual narrative constructed by the ‘before and after’ galleries distinguishes the ‘ideal’ or ‘normal’ vulval appearances from that of the ‘abnormal’ or ‘undesirable’ pre-operative genital images. The websites also provide descriptions of women’s reasons for undergoing the procedures. They use the following terms to describe the post-operative aesthetic appearance of women’s genitalia following labiaplasty and vaginoplasty: *smooth, sleek, symmetrical, trimmed, refined, firm, tight, slim, thin, athletic, petite, ‘clamshell’, contoured, desirable, neat, youthful/younger-looking, rejuvenated, appealing, comfortable*, and as a ‘*single line.*’ In contrast, the websites all describe ‘elongated’ and ‘protruding’ labial tissue of the labia minora as being *excessive, awkward, disconcerting, uncomfortable, painful, undesirable, unsightly, unpleasant*, and *unattractive*. The negative connotations associated with pre-operative genitalia on these Canadian websites reaffirm feminist scholars’ claims that FGCS marketing representations of the vagina are derogatory, depicting mature women’s genitalia as “unpleasant, odorous, and unattractive” (Braun & Wilkinson, 2001: 23). Furthermore, these websites appear to rely on women’s lack of awareness of female genital diversity,



to convince them that the post-operative genital depictions displayed on their websites are actually indicative of ‘normal’ genital morphology, thus creating a new uniform norm. Indeed, these websites reproduce contemporary discourses of sexual shame by deploying restrictive medical and aesthetic discourses, which pathologize pre-surgical genitalia through explicitly differentiating between ‘normal’ and ‘abnormal’ or ‘right’ and ‘wrong’ genitalia for women, and consequently privilege a ‘girlish’ and sexually immature genital appearance (Moran & Lee, 2013: 5-6).

Many feminist scholars and activists suggest that public awareness of vulva diversity is crucial in challenging FGCS. In *The New View Campaign*’s online promotional and educational materials, they noted that “popular knowledge about women’s vulvas comes disproportionately from commercial sources such as magazines, pornography, and on-line surgery sites that are likely to digitally alter or airbrush genital images or include only selected models” (NVC, 2011). Images of real women’s bodies are also absent from public school sex education texts; these texts focus solely on pregnancy and disease prevention (NVC, 2011). This distortion and silence results in widespread ignorance and genital shame and likely increases women’s and girls’ vulnerability to ads and TV shows promoting FGCS. Further, the surgeons’ websites for FGCS have misleading claims about sexual improvement, enhancement, and responsiveness, which will be explored in more detail in my section concerning ‘vaginal laxity’ (NVC, 2011).

Arguably, the inaccurate and limited vulva representations in the media limit women’s ability to make informed decisions about their genital appearance prior to consenting to FGCS procedures. In a critical online discussion about the medical ethics of

FGCS, Goldstein and Goldstein (n.d.) questioned whether the lack of accurate representations of female genitalia in the media impairs women's ability to make an informed choice, which is vital for one to offer their fully informed consent—a foundational premise of contemporary health care and medical ethics that is prized by feminist health advocates (Braun, 2009b; Tiefer, 2008).<sup>41</sup> Goldstein and Goldstein (n.d.) posited their query against the backdrop of other women's experiences of undergoing rhinoplasty or breast augmentation:

Women who make informed choices about having their nose done or their breasts augmented have seen thousands—maybe hundreds of thousands—of real noses and breasts. True, they may be swayed in their cosmetic choices by cultural standards of attractiveness, but at least they have a vast reservoir of visual experience from which to draw when deciding whose conception of beauty they wish to emulate. Most women who choose cosmetic genital surgery have seen but a few dozen photos of airbrushed vulvas, and maybe a handful of real vulvas, too (quoted in Braun, 2009b: 238).

Therefore, Braun (2009b: 238) suggests that the questionable ethics surrounding FGCS must be considered in a context where “‘informed choice’ cannot *really* be seen to exist because the exposure to *real* vulvas is so (presumably) limited that women's ‘choice’ for a certain aesthetic cannot be seen as a valid, authentic, real—*informed*—choice” (emphasis in original). Although, Goldstein and Goldstein (n.d.) offer a significant critique of FGCS, this position nonetheless, insinuates that the main problem concerning the ethics of FGCS, is the lack of ‘*real*’ choice based on the lack of ‘*real*’ and accurate representations of the diversity of women's genitalia (Braun, 2009b: 238). More simply put, this means FGCS procedures could be considered ethical if women were exposed to multiple (and real) vulva representations, as this would result in a patient's informed (and

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<sup>41</sup> Feminist scholars have not overlooked the irony of this situation in which there could be concerns about patients ability to consent to an elective procedure they have ‘independently’ sought out for themselves (Tiefer, 2008: 472).

implicitly free) choice (Braun, 2009b: 238). Therefore, once ‘choice’ is perceived to be *real* and truly *informed*, the practice of FGCS becomes acceptable (Braun, 2009b: 238). However, in assessing the contemporary depictions of women’s genitalia across a wide range of media sources and contexts, including women’s magazines, pornography, linguistics, and medical texts and literature,<sup>42</sup> it becomes dishearteningly apparent that Western society’s representations of women’s genitalia are riddled with notions of ‘pudendal disgust’ and misogyny. Therefore, any effort to accurately portray women’s genital diversity would have to involve an unprecedented cultural shift, which if successful, could unsettle women’s desire for FGCS in the first place. Nevertheless, I agree with Goldstein and Goldstein (n.d.) that women choosing to undergo FGCS procedures are misinformed, due to the wider societal ignorance of women’s genital diversity that is exacerbated by the ‘enhanced’ representations of women’s genitalia in the ‘before and after’ photographs found on several of the Canadian FGCS provider websites, as well as in mainstream pornography (Tiefer, 2008).

## **The Pathologization of ‘Hypertrophic Labia’**

### **The Authority of Medical Language**

In Barbara L. Marshall’s (2002) essay, *‘Hard Science’: Gendered Constructions of Sexual Dysfunction in the ‘Viagra Age’*, she connects a complex array of distinctly modern phenomena to the contemporary trend for biomedical intervention in sexual function (and dysfunction), a context which explains the success of Viagra, and accounts

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<sup>42</sup> Please refer to the following articles for a more detailed discussion and coverage of socio-cultural representations of women’s genitalia: Socio-cultural – Braun & Wilkinson (2001); Language and Linguistics – Braun & Kitzinger (2001a); Braun & Kitzinger (2001b); Visual depictions in women’s magazines, feminist media, and pornography – Bramwell (2002); Howarth et al. (2010); Schick et al. (2011); Women and pubic hair – Braun et al. (2013); Medical and gynaecological literature – Braun (2003); Scully & Bart (1973); Sex education and high school health texts – Elliot (2003).

for the growing popularity and acceptance of FGCS. Marshall (2002: 134) addresses two significant shifts, the first being “the rise of science as the authenticating voice on what constitutes the ‘normal’ and ‘abnormal’, and [the] second, a reframing of the ‘abnormal’ to emphasize *dysfunction* rather than moral *danger*” (emphasis in original), which have both been advantageous shifts for the FGCS industry. The increased importance of so-called ‘expert systems and knowledges’ in managing our everyday life has in turn granted FGCS physicians’ authority and legitimacy in the discussion and treatment of women’s concerns over their genital appearance (Marshall, 2002: 134). Arguably, these shifts allow physicians and surgeons to pre-emptively create the very ‘conditions’ that they conveniently intend to ‘treat’ (Rodrigues, 2012). According to Weil Davis (2002: 10), “bringing the authoritative language of medical science to the aesthetization of the vagina is one key way to trigger [genital] anxiety.” I argue this process is crucial to the depiction of elective cosmetic procedures, such as FGCS, on Canadian provider websites.

The authoritative power medical language has in recasting normal bodily variation into ‘pathological’ conditions in need of medical treatment is best exemplified by the shift in medical perceptions concerning ‘small breasts’ (Braun & Tiefer, 2010: 3). Beginning in the 1950s, small breasts were no longer perceived to be a natural variation in the fat deposits of women’s mammary glands, but rather were pathologized into the ‘deformity’ of ‘hypomastia’ or ‘micromastia’—the disease of flat-chestedness—a ‘condition’ that persists to this day, although now for ‘inadequate’ rather than for the more demeaning ‘absent’ breasts of the past (Braun & Tiefer, 2010: 3; Weil Davis, 2002: 10). The medical treatment remains the same—mammoplasty/breast augmentation/breast ‘enhancement’—which has become one of the most popular and requested cosmetic

procedures (Braun & Tiefer, 2010: 3). The questionable advertising of this medicalized shift in acceptable breast size resulted in “many physically normal women develop[ing] an almost paralyzing self-consciousness [or inferiority complex] focused on the feeling that they [did] not have the correct size bosom” (Weil Davis, 2002: 11). The practice of pathologizing female bodily diversity now extends to women’s genitalia, as labiaplasty corrects for ‘hypertrophic’ labial tissue (Braun & Tiefer, 2010)

The ‘aesthetics’ of the vulva and vagina were largely ignored by gynaecologists and cosmetic surgeons until relatively recently. According to Weil Davis (2002: 11), the vulva and vagina were previously “spared from the scrutiny of the market because it was considered both too reviled and too quakingly desired to be addressed commercially.” However, once ‘hypertrophic labia’ or ‘labial hypertrophy’ entered medical discourse, vulva aesthetics became a new area of medical specialization. ‘Hypertrophic labia’ refers to when the labia minora (unilaterally or bilaterally) ‘protrudes’ beyond the distal edge of the labia majora (Braun & Tiefer, 2010: 3-4; Miklos & Moore, 2008: 1493). This protrusion is considered problematic if it extends from 2cm to 5cm (Braun & Tiefer, 2010: 4) and according to Rouzier et al., (2000: 35) the labia minora qualify as ‘hypertrophic’ when “the maximal distance between base and edge is >4cm.” The resulting protrusion has been described to rest in “a winglike fashion from the vulva and look like *spaniel’s ears*” (emphasis added, Rouzier et al., 2000: 35). Despite inconsistent definitions of ‘hypertrophic labial’ length, labial asymmetry is a commonly agreed upon ‘morphological defect’ of the genitalia (Moran & Lee, 2013: 2). The ‘linguistic ambiguity’ or rather the lack of definitive medical parameters for this ‘condition’ allows surgeons flexibility in their decisions regarding who actually has ‘labial hypertrophy’

(Braun, 2009a: 138). This can widen cosmetic surgeons' client base significantly as definitions are not clear, thus leaving more women to question if their labial dimensions signify a previously unknown medical condition (Braun, 2009a: 138). This ambiguity appeared on all the Canadian FGCS provider websites offering labiaplasty, as they employed extremely vague and ambiguous definitions of 'Hypertrophic Labia' or the problematic 'condition' of 'protruding' or 'excessive' labia minora. The best example of this lack of definitional clarity can be seen on Clinic 360's website, where the term 'Labial Hypertrophy' was simply followed by the word 'enlargement' in brackets. There was no further explanation provided, which could potentially leave some individuals confused over whether the term refers to the inner or outer labial lips, thus inflating the area of potential genital distress. The remainder of FGCS provider websites that explicitly employed the authoritative medical term 'labial hypertrophy' stated that the labia minora were *wide*, *excessive*, *long(er)*, and/or *large(r)*. However, it was not always clear if this was in reference to another anatomical part of the vulva, for example in comparison to the labia majora or was simply indicative of one's personal and subjective assessment of the labial minora tissue.

My Canadian sample of FGCS provider websites highlights their use of medical and aesthetic discourses to denote the 'undesirableness' of elongated labia minora. While not all websites explicitly labeled elongated or protruding labia minora as 'labial hypertrophy' they nonetheless emphasized that it was a problematic 'condition' due to the 'excess' or 'protrusion' of labial tissue, which they suggested may cause embarrassment or discomfort and pain with daily activities and/or during sexual intercourse. Braun and Tiefer (2010: 4) suggest that medical professionals' use of the

terms, ‘protrusion’ or ‘excess’ in describing certain labial lengths invokes a sense of genital abnormality, whereas employing the label or diagnosis of ‘hypertrophy’ firmly cements elongated labia within the realm of the medical and pathological. Therefore, through the skillful application of descriptive and medicalized language—as seen across the 10 Canadian FGCS provider websites—a previously ‘normal’ bodily variation is medicalized and pathology guaranteed (Braun & Tiefer, 2010: 4). Braun and Tiefer (2010: 4) argue that, “with the willing uptake of this condition, a surgical solution is implicitly rationalized and justified, over other possible ‘solutions’ – because this becomes a real and authentic (material) problem, it needs to be resolved.” This language, then, reaffirms medical control and dominion over the newfound ‘condition.’

Consequently, the emergence of the term ‘labial hypertrophy’ is troubling for women’s gynaecological and sexual health. Lloyd et al. (2005: 645) examined the anatomical dimensions<sup>43</sup> and configuration of adult female genitalia and found that, “there is far greater diversity than previously documented relating to labial and clitoral size, colour, rugosity, vaginal length and urethral position.” In addition, Braun and Tiefer (2010: 3) claim that long labia that extend beyond the labia majora are statistically ‘normal’ and possibly more common than concealed ones (source Corinna, n.d.).<sup>44</sup> Based on these findings, Braun (2009a: 138) vehemently argues that the term ‘labial hypertrophy’ reflects only a subjective and rhetorical claim because it is not founded in science. Despite the term’s lack of scientific rigor and identifiable labial pathology, increasing numbers of articles are being published detailing new surgical techniques for

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<sup>43</sup> The morphological parameters measured included: clitoral and labial length, width, colour, and wrinkledness (Lloyd et al., 2005). The participants were 50 pre-menopausal women (aged 18-50 years), none of whom had any concerns regarding their genital anatomy. This is a relatively small sample, and therefore lacks generalizability to the general population.

<sup>44</sup> Rouzier, et al. (2000: 39) claim that ‘labial hypertrophy’ is rare.

the excision of ‘excess’ labial tissue in order to properly manage this invented ‘condition’ (Braun, 2009a: 138).

The recent pathologization of ‘hypertrophic labia’ has been informed by a long cultural history and medical narrative, which associates ‘large’ labia minora or female genital ‘excess’ with pathology and sexual deviance (Braun, 2009a; 2005a). In Sander L. Gilman’s (1999) historical analysis of cosmetic surgery in his book, *Making the Body Beautiful: A Cultural History of Aesthetic Surgery*, he suggests that the stigmatized nature of long labia in the West may stem from the racial stereotyping of Black women’s bodies (and sexualities) and the belief that long labia denote sexual promiscuity (Bramwell et al., 2007: 1497). Braun & Tiefer (2010: 4) note that throughout the 19<sup>th</sup> and 20<sup>th</sup> century, “the genitalia of women deemed inherently suspect either by race (e.g., Black women) or by sexuality (e.g. lesbian women; prostitutes) have been subject to scientific scrutiny.”<sup>45</sup> For example, in the early 19<sup>th</sup> century, European medical scientists had an eroticized and reproachful fascination with the genitalia of Saartjie (Sara) Baartman, a Southern African Khoikhoi woman, known as the Hottentot Venus, who was exhibited across Europe for her infamous ‘steoptygic’ or ‘steatopygia’ buttock (the prominent accumulation of fat on the buttock) and her ‘Hottentot apron’ (elongated labia) (Braun & Tiefer, 2010: 4; McDougall, 2013: 778; Weil Davis, 2002: 18). Renowned scientist and Father of Paleontology, Georges Cuvier, subjected her to an examination and upon her early death in 1815 he dissected her remains and displayed her brain,

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<sup>45</sup> The bodies of African American slaves and poor, disenfranchised white ‘washerwomen’ were repeatedly subjected to public operations and experimentation by such founding American gynecologists as J. Marion Sims for the development of gynecological techniques and surgeries that would benefit and were developed for the upper-middle-class and upper-class ‘ladies of leisure’ (Weil Davis, 2002: 16, 19).



skeleton and genitalia at the Musée de l'Homme (Museum of Man) in Paris, France,<sup>46</sup> and these remained on public display until 1974. Within the early 19<sup>th</sup> century scientific community, Baartman's genitalia became emblematic of racial classifications of African women's 'abnormal,' 'wild' and 'savage' 'animal-like' nature and promiscuous/rampant sexuality, a discourse which served to differentiate African women from 'normal' and 'respectabilized' European/Caucasian women (McDougall, 2013; Weil Davis, 2002).

Additionally, 19<sup>th</sup> and 20<sup>th</sup> century scientists measured and catalogued prostitutes and lesbian women's external genital morphology for their 'alleged anatomical excesses' in order to, "determine [the] pathological difference, inappropriate feminine embodiment and (hyper) sexuality...[of] genital excess" (Braun & Tiefer, 2010: 4). According to Weil Davis, (2002: 15) the association of large labia with 'deviance' has been around since at least the 16<sup>th</sup> century, and has been discursively connected to "the presence of hypersexuality, onanism, and possible 'tribadism' or lesbian tendencies." Furthermore, certain features of women's genital morphology have been labeled 'masculine.' For instance, Havelock Ellis, an English physician in 1915, described the labia majora of lesbian women as resembling 'fleshy sacs' (Braun & Tiefer, 2010: 5). Somerville suggests Ellis' reference to 'fleshy sacs' "invoke[s] the anatomy of a phantom male body inhabiting the lesbian's anatomical features" (quoted in Braun & Tiefer, 2010: 5-6). Braun and Tiefer (2010: 6) conclude that, "In interpreting certain female genital morphology as 'masculine,' these accounts reveal the societal importance of visible gender dimorphism." They go on to link the logic of gender dimorphism to the practice of both FGCS and Male Genital Cosmetic Surgery (MGCS), as the reduction and tightening

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<sup>46</sup> Her remains have since been returned to her homeland (now South Africa) and were properly buried on August 9<sup>th</sup>, 2002.

of genital tissue is paramount in FGCS, whereas the aim of MGCS procedures is to enlarge the size and girth of the penis. Thus both groups of procedures exaggerate the secondary sexual characteristics of both sexes, which reifies the sex differences between women and men and contributes to the dichotomous genital-gender system<sup>47</sup> (Braun & Tiefer, 2010: 6; Braun & Wilkinson, 2005: 519; Stuart & Donaghue, 2011: 99).

Hence, it came as no surprise that depictions emphasizing visible gender dimorphism were routinely invoked on the Canadian FGCS provider websites through negatively encoded ageist and gendered discourses. In addition to the descriptive language and visual depictions discussed earlier in my analysis—which emphasized the desirability of the ‘absent,’ ‘smooth,’ and ‘contained’ female genital appearance—the websites used the following language and phrases to disparagingly link long labia minora to masculine attributes: *long thick hanging, hanging effect, bulge/bulging (visible through clothing), larger than necessary, fatty, flaccid, distorted, misshapen, over-developed, puffy, protruding, ‘woman balls’ or ‘camel foot’ look, saggy/sagging, and drooping*. In Lindy Joan McDougall’s (2013: 777) paper, *Towards a clean slit: How medicine and notions of normality are shaping female genital aesthetics*, she argues that, “By describing these women’s genitals in terms of male genitalia, these surgeons are inferring that longer labia are not just aesthetically displeasing but also masculine in nature and therefore inappropriate for a heterosexual woman.” Therefore, the recent introduction of FGCS procedures and the subsequent exaggeration of visible gender dimorphic

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<sup>47</sup> Braun and Tiefer (2010) suggest that the practice of breast augmentation is similarly based on notions of gender dimorphism, as the procedure ‘corrects’ for the ‘absent’ female breast. Upon initial assessment these two cosmetic procedures appear drastically different, however, both procedures, “identifies as pathological a body that blurs the boundaries between distinctly ‘female’ or distinctly ‘male’: hypomastia renders the chest potentially ‘male’; [whereas] ‘too long’ labia render the vulva open to a male reading” (Braun & Tiefer, 2010: 5).

differences promote limited cultural configurations of ‘appropriate’ femininity onto women’s bodies and construct them as resolutely pre-social and thus less open to redefinition (Marshall, 2002: 145).

The cultural idealization of ‘diminutive’ labia minora valorizes women’s genitalia being returned to a juvenile or prepubescent state, which denotes a pre-sexual body and upholds longstanding social constructions of female sexual anatomy and women’s ‘appropriate’ sexual behaviour and demeanour as ‘absent’, ‘subdued’ and ‘submissive’ (Braun & Tiefer, 2010; Fitzpatrick, 2007; Liao & Creighton, 2007; Manderson, 2004; Schick et al., 2011). This appears to be counterintuitive to the marketing found on FGCS provider websites, as they proclaim FGCS surgeries increase and enhance women’s sexual gratification and pleasure (Braun, 2005a; Braun & Tiefer, 2010). However, Braun and Tiefer (2010) suggest that the contemporary practice of FGCS is not so dissimilar to the scientific classifications of lesbian and African women’s genital morphology and the 19<sup>th</sup> and 20<sup>th</sup> century practice of clitoridectomies in the West discussed earlier. They suggest that FGCS is “about the policing or production of *appropriate* embodied [white] (hetero)sexuality for women” (emphasis in original, Braun & Tiefer, 2010: 5). Although, Braun and Tiefer (2010) acknowledge that ‘long’ or ‘messy’ labia minora have historically been read to indicate ‘promiscuity’ and sexual deviance and remain highly stigmatized, they nevertheless theorize another explanation for what is contemporarily occurring with FGCS. They suggest that ‘long’ labia and ‘loose’ or ‘stretched’ vaginas signify to women, “a body ‘unfit’ for – undeserving of – sexual activity, and, even of questionable womanhood”<sup>48</sup> (Braun & Tiefer, 2010: 5). Similarly, Schick et al. (2011:

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<sup>48</sup> Braun & Wilkinson’s (2005) article, *Vagina equals woman? On genitals and gendered identity* discusses the assumption that men and women’s gendered identity is based on the prior existence of dichotomously

78) contend that the ‘Barbie’ or ‘absent’ genital aesthetic found in the pages of *Playboy* and promoted on FGCS websites simply represents a natural progression from the historical and sociocultural constructions of women’s sexuality and longstanding stigmatization of elongated labia minora.

### **The ‘Barbie’ or ‘Smooth’ Labiaplasty and Traditional Female Genital Cutting**

The ‘Barbie’ or ‘Smooth’ labiaplasty offers women the most exaggerated version of gendered-genital difference, as the procedure results in a truly minimal or ‘absent’ genital aesthetic. Clinic 360 refers to these procedures as “the most dramatic type of labiaplasty, [because] the labia are *mostly* or *completely excised*” (emphasis added). This procedure is rumoured to have been invented by an American doctor in response to women’s increasing requests for a ‘*perfectly smooth look*,’ which resembles that of its namesake, the iconic Barbie Doll (emphasis added, Toronto Cosmetic Clinic; Clinic 360; Edelstein Cosmetic). Edelstein Cosmetic in Toronto notes that this procedure “has been a very popular look for women in Southern California... and the trend has been picked up all the way up here, in Canada.” On the Toronto Cosmetic Clinic’s website, the clinic provides the following description of a ‘Barbie’ labial reduction:

During this procedure, most – or all – of the labia minora (the “inside lips” of the vulva) is removed, to create a completely *tight* and *petite look*. By removing this part of the vulva, the labia majora is allowed to close tightly, creating a *smooth “single line” opening*. In cases where the labia majora is enlarged or appears “*saggy*”, this part of the vulva is also trimmed down to enhance the *streamlined appearance*. The result can be *quite stunning!* This is one of the *more comprehensive* forms of labiaplasty, so we remind our clients that reversal of the procedure is not easily performed (Toronto Cosmetic Clinic - italics added for emphasis).

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sexed bodies (visible gender dimorphism). For example, the idea that the penis likens maleness and the vagina (or absence of a penis) equates femaleness or womanhood.

Similarly, Clinic 360 states the following on their website about the ‘Barbie’ or ‘Smooth’ Labiaplasty:

It creates a *refined, petite, minimalist look* that should completely eliminate the uncomfortable feelings of pulling or rubbing to which enlarged labia are prone. Once the labia minora are removed, the labia majora can close more tightly, giving the appearance of a “*single line*” opening. In cases where the labia majora appear enlarged or *saggy*, they can be shaved down to enhance the *streamlined appearance*. Patients are reminded that because this is a *more comprehensive* type of labiaplasty, reversals are not easily performed (Clinic 360 - italics added for emphasis).

The final clinic to offer the ‘Barbie’ describes the procedure as such:

The Barbie is a specific type of labiaplasty that involves a total reduction of the labia minora (inner lips), allowing the labia majora (outer lips) to close together better. Because there is very little to no labia minora remaining, the look is considered *minimalist* and *sleek*. From long, protruding labia minora to a *streamlined* and *flatter* appearance that has everything “*contained*”, the improvement achieved can be *quite dramatic!* (Edelstein Cosmetic – italics added for emphasis).

All three of these clinics’ descriptions of the ‘Barbie’ are eerily reminiscent of the desired ‘smooth’ look of some forms of traditional Female Genital Cutting (FGC),<sup>49</sup> a practice that is illegal in much of the West, including Canada.<sup>50</sup> The enthusiastic and positive declarations that the ‘Barbie’ results in a *stunning, dramatic* and *comprehensive* look as the post-surgical aesthetic appears—*tight, refined, petite, minimalist, sleek, streamlined, smooth, contained*, and as a ‘*single line*’ opening—are highly suggestive of aesthetic descriptions used in support of traditional FGC to invoke an ‘appropriately’ gendered and ‘feminine’ genital appearance. Importantly, the amount of labial minora tissue excised

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<sup>49</sup> I use the more ‘neutral’ descriptive term Female Genital Cutting (FGC) in place of Female Genital Mutilation (FGM), because the latter has been publicly criticized and increasingly abandoned by NGOs for being offensive and highly stigmatizing towards the individuals who have undergone the practice (Braun, 2012: 33; Johnsdotter & Essén, 2010: 30). Additionally, Green (2005: 155) contends this conceptual change assists in shifting thinking from that of the victimization of women and girls to one of “the larger, more complicated cultural contexts.”

<sup>50</sup> The practice of FGC has been criminalized in Canada since 1997. The law additionally forbids parents and/or guardians from sending children to another country to undergo the procedure (Green, 2005: 159).

from women undergoing the ‘Barbie’ falls under Type IIa of the World Health Organization’s (WHO) classification of Female Genital Mutilation.<sup>51</sup>

I do not deny that there are a number of key distinctions that separate the traditional practice of FGC from FGCS,<sup>52</sup> but in drawing attention to the aesthetic and anatomical parallels, as well as the similarities of the descriptive language employed by individuals involved in both of these practices, I aim to expose the racialized legal inconsistencies of the Canadian law, as it prohibits traditional FGC while allowing the FGCS industry to flourish unregulated—a hypocritical practice that numerous scholars have also noted (i.e. Berer 2010; Braun, 2012; Johnsdotter & Essén, 2010; Kennedy, 2009; Weil Davis, 2002). Braun (2009a: 135) has remarked on the commonalities between FGCS and traditional FGC by noting that both practices aim to produce “a culturally ‘appropriate,’ and desirable, genital appearance, and one which is ‘properly’ gendered.” Furthermore, Braun (2009a) acknowledges that at the material level there are similarities between some of the procedures associated with the two practices. In terms of the procedures that target the vagina, they both involve the narrowing and tightening of the vaginal canal via the vaginal opening (Braun, 2009a: 135). As for the procedures that target the labia minora, the aim is to reduce or excise the ‘excess’ labial tissue (Braun, 2009a: 135). Braun (2009a: 135) concludes that both practices “reflect cultural pressure and expectations of appropriate, and sexually/relationally desirable, femininity and womanhood.” Similarly, Weil Davis (2002: 23-24) argues that the key factors raised by

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<sup>51</sup> According to the WHO’s classification of FGM, Type II involves, “partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora.” This division is further dividing into subcategories, with Type IIa signifying “the removal of the labia minora only” (information obtained from: <http://www.who.int/reproductivehealth/topics/fgm/overview/en/>).

<sup>52</sup> Contextually, the practices of traditional FGC and FGCS are remarkably different. The practice of FGCS is performed on ‘consenting’ adult women by trained medical experts in sanitary conditions. Whereas, traditional FGC is typically performed in unsanitary conditions by non-medical experts on non-consenting female children and infants (Johnsdotter & Essén, 2010: 32).

African women who favour female genital surgeries should not be perceived as radically distinct from those offered by Western women seeking FGCS procedures, as both groups are influenced by a desire for vulval beautification and conformity, as well as the transcendence of shame. Nevertheless, the Canadian law was amended in May 1997 to include the performance of ‘FGM’ as aggravated assault under section 268(3) of the Criminal Code, but with the exception that this provision “not apply to [the] legitimate medical procedures performed by duly qualified physicians for the physical health of the person” (Huston, n.d.: 9). Thus the practice of FGCS in Canada is exempt from 268(3) of the Criminal Code, despite the striking similarities between the WHO’s classification of Type IIa FGC and the smooth ‘Barbie’ labiaplasty of FGCS. Clearly, the ‘cultural’ distinctions that legally separate these two procedures are the outcome of racialized Western discourses of medicalization legitimized by the state.

In Aileen Kennedy’s (2009: 219) analysis of the different legal responses to traditional FGC and FGCS in New South Wales (NSW), Australia—which is similar to Canada’s position—she suggests that in the West, “cosmetic surgery discourse abounds with instances of cultural practice that is experienced as [biological] fact, truth or reality.” Western experiences of embodiment are predominantly interpreted through medical discourse and are perceived as objective, biological facts, with the cultural context removed (Kennedy, 2009). Ultimately, this hermeneutic informs the dichotomy of Western legislation concerning traditional FGC and FGCS. Traditional FGC has become a matter of ‘culture’ and ‘ritual’ that is perceived as ‘unnatural’ and ‘mutilating,’ whereas the FGCS is a matter of ‘health’ and ‘medical welfare’ that is represented as ‘natural’ and ‘normal’ rather than as ‘constructed’ (Kennedy, 2009: 219). Kennedy (2009: 226)

suggests this differentiated conceptualization of female genital practices and agency, as well as the ensuing legislation reflects, “[the Western] perception of [other’s] culture as an oppressive force, which negates true agency.” This means that, “[any] desire to comply with cultural pressure is not an expression of autonomy but [rather] a symptom of oppression...therefore, consent to FGM cannot be seen as genuine or authentic”

(Kennedy, 2009: 226). In addition, Weil Davis (2002: 21) claims Western laws forbidding the practice of traditional FGC have consequently “marked out relations between the state and its citizen bodies that differ depending on birthplace, cultural context, and skin colour,” which is arguably the case in the federal Canadian government’s interpretation of traditional FGC and the Western practice of FGCS.

The West’s aversion to critically self-reflect upon their own cultural beauty practices is best exemplified in a statement made by Soraya Miré, a Somali human rights activist, award-winning documentarian filmmaker, and survivor of FGC:

The problem with a lot of Western women is they think they can *help* me, they think they *know what’s best* for me. Especially feminist women. They come into conversations waving the American flag, forever projecting the idea that they are more intelligent than I am. I’ve learned that American women look at women like me to hide from their own pain. They can’t face their pain, and mine is so obvious, they think they can help me without looking at themselves...In America, women pay *the money that is theirs and no one else’s* to go to a doctor who cuts them up so they can create or sustain an image men want. Men are the mirror. Western women cut themselves up voluntarily...Western women *pay* to get their bodies mutilated (emphasis in original, quoted in Muscio, 2002: 125-126).

Miré suggests Western women’s willingness to voluntarily pay and subject themselves to elective surgical cosmetic procedures highlights the degrading depths of Western women’s oppression and self-delusion that they are ‘doing it for themselves.’ Although her position is not representative of all Western women, it nonetheless strikingly resonates when we recognize that some Western women are ‘choosing’ to undergo a



cosmetic procedure that is aesthetically similar to Type IIa of the WHO's FGC classifications. Through her statement, Miré challenges, "the supposition that culture itself is a non-Western phenomenon and that Westerners are not themselves enculturated" (Meyers, 2000: 474, quoted in Kennedy, 2009: 219). This representation of 'culture' (i.e. which is only applied to the racialized or 'barbaric' 'other') appears to inform the highly racialized interpretation of Female Genital Cutting practices in Canada, as the existing legislation reaffirms the civilized/uncivilized binary (Kennedy, 2009; Weil Davis, 2002: 24).

### **FGCS as Rejuvenation: The Medicalization of Vaginal Laxity, Relaxation, and 'Looseness'**

The main cause of women's diminished sexual pleasure is consistently represented in online material as a lack of friction due to vaginal laxity, 'looseness,' or relaxation as a result of aging and/or childbirth. Here vaginoplasty or Laser Vaginal Rejuvenation® is always presented as the solution. First Glance stated that, "No one wants to age or lose optimal function anywhere, and this includes the vaginal and vulvar structures: LVR® has the solution. We have found that the vaginal and vulvar issues women are self-conscious about can be solved with LVR®." The discourse of youthfulness is repeatedly invoked through the marketing assertions that vaginoplasty would *rejuvenate, revitalize, and restore vitality, strength, control, tone, lost sensitivity* as well as one's *lost youthful appearance, firmness, and elasticity* and return a woman's vagina to its *pre-pregnancy appearance and state*. Clinic 360 even went as far as to say the procedure was like a "'Face-lift' for the vagina." This discourse was essential in medicalizing normal bodily changes that result from pregnancy, childbirth, and aging, as

well as in constructing them as “unacceptable medical problems that require surgical correction” (Moran & Lee, 2013: 10). However, Braun (2009a: 138) argues that:

This valorization of youth, associated with both cosmetic surgery discourse and consumer culture, ‘locks’ anatomy and aesthetics into a certain point in development, constructing any subsequent change as bad...with aging inevitable, it works to construct a potentially infinite client base for surgeons.

Therefore, it appears that by medicalizing aging, these websites are manipulating and exploiting women’s fears of aging and physical decline, which Gillespie (1996: 78) suggests, “may reinforce the pathological relationships that many women have with their bodies.”

Normal bodily states are further medicalized through framing pre-surgical vaginas as an impediment to women’s and their partners’ sexual satisfaction and pleasure. For example, the Toronto Cosmetic Surgery Institute stated that, “weak vaginal muscles can lead to sexual problems and dissatisfaction for both partners” and therefore, it invites women to “rejuvenate [their] love life” with vaginoplasty. The Toronto Cosmetic Clinic asserts:

With age and the intense stress of childbirth, many women experience weakening of the muscles in their vagina. With loose muscles in the area the ability to create friction is dramatically reduced, thereby adversely affecting sexual gratification. Sexual gratification has been scientifically proven to be intimately linked to the level of friction created.

These statements position a ‘tight’ vagina as crucial to achieving adequate sexual stimulation for one’s sexual and orgasmic pleasure, thus reaffirming a ‘coital imperative’ in heterosex (Braun & Wilkinson, 2005: 512). Additionally, the websites’ implication that vaginal tightening is primarily useful to increase women’s sexual pleasure suggests that these claims are “scientifically proven” however, there is no literature to back up this claim. In contrast, feminist critiques of these procedures suggest they are actually

principally focused on male/penile sexual pleasure (Braun & Kitzinger, 2001c: 265).

Rodrigues (2012: 789) argues that vaginal tightening:

move[s] women's sexual pleasure away from the clitoris and in turn reinforce[s] the long-standing assumption that, during penetrative sex, 'normal' women should experience pleasure and come to orgasm vaginally, despite the fact that vaginal stimulation alone does not bring the majority of women to orgasm, a misconception that has been famously and vehemently disputed.

Therefore, discourses perpetuated through provider websites that imply that menopausal and/or postpartum vaginas are deficient, and that vaginal tightening is the solution for diminished sexual pleasure "regulates female sexuality by creating specific, limited terms of sexual being and expression" (Rodrigues, 2012: 789).

Additionally, the disputed, yet all too common claim that vaginal tightening 'strengthens' and 'tones' vaginal muscles riddled the webpages of my sample. For example, on New Woman Canada's (2015) website, the clinic claims that Vaginal Rejuvenation "strengthens vaginal muscle tone and control to enhance sexual gratification." However, Braun (2009a: 141) disputes this often-repeated claim by arguing that vaginal tightening cannot improve a women's vaginal muscle tone, because the muscle remains unchanged,<sup>53</sup> rather the procedure "brings the muscles closer together, and removes "excess" vaginal tissue." Surprisingly, in discussing patient expectations and outcomes following vaginoplasty, only Clinic 360 stressed online to potential patients that, "vaginal tightening does not guarantee sexual satisfaction, [as it] is a highly subjective and complex mechanism that is reliant on a number of factors."

Nevertheless, Clinic 360's descriptions of the potential benefits to undergoing

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<sup>53</sup> Muscle tone and strength can only be improved through continual use and conditioning (i.e. through the contraction and relaxation of the muscle fibers).

vaginoplasty were highly suggestive, for example, by claiming the procedure “can increase friction during intercourse and lead to greater sexual satisfaction.”

Two surgeons not associated with the 10 Canadian websites I analyzed have acknowledged the centrality of male sexual pleasure in FGCS procedures. Toronto based plastic surgeon Dr. Robert Stubbs disclosed that the majority of his patients who undergo vaginoplasty are doing it for the sexual satisfaction of their male partners, while Dr. Gary Alter admits that “men routinely tag along to consultations, leaning over his shoulder as he inspects their lover’s crotch to suggest changes” (Scheeres, 2006: 263). Dr. Stubbs also notes that these new surgical techniques “are no more than a twist on the postpartum ‘husband’s knot’ [as previously discussed in Chapter 2], wherein the obstetrician throws in a few extra stitches” in order to create a tighter fit for a penis (Scheeres, 2006: 263). Consequently, it seems at least two physicians involved in providing these surgeries acknowledge that the main purpose of vaginoplasty is to “reinforce the instrumental function of the vagina in normative heterosexuality” (McNamara, 2006: 10). Insofar as the vagina remains the primary site of sexual pleasure for the male sexual organ (at least in heterosex), when a “vagina fails in this capacity and is no longer able to deliver adequate stimulation to the penis, a cultural intervention is required” (McNamara, 2006: 10).

I argue women’s sexuality needs to be recognized outside of the heteronormative framework, which privileges male heterosexual pleasure and the importance of penile penetration and stimulation over women’s sexual pleasure. FGCS websites reinforce the evolutionary functionalist theory, which claims that “women were created as a receptacle for male desire” (Braun & Wilkinson, 2001: 20). The idea of penile receptivity and the

centrality of vaginal penetration construct how women should experience sexual pleasure, a process that is evident in the practice of vaginoplasty, where the sole aim is to provide a snugger fit for the penis (Braun, 2009a: 137; Braun & Wilkinson, 2001: 20). Furthermore, the increasing popularity of this procedure suggests that it is critical to critique the postfeminist discourse that women are sexually liberated in the West and are undergoing these surgeries for themselves.

### **Neoliberal and Feminist Rhetoric Undermines Criticism of FGCS**

Feminist scholarship investigating contemporary representations of women in advertising note the emergence of a 'postfeminist figure' which depicts the modernized version of white heterosexual femininity to be active, feisty, sassy, independent and sexually powerful (Gill, 2008a: 438; Gill, 2008b: 35). According to Rosalind Gill, the rise of this new 'postfeminist sensibility' is distinctive from previous advertising, which frequently portrays women as passive objects of the male gaze (Gill, 2008a: 437; Gill, 2008b: 35). Part of this shift stems from the advertising industry's awareness of young consumers' 'viewer skepticism' and 'sign fatigue,' and the industry's attempts to flatter consumers by acknowledging that the consumer is "too knowing and sophisticated to be 'got at' by the advert" (Gill, 2008a: 436-437). This, in turn, creates advertising discourses that appear not to be selling or promoting anything, but rather "stress that in buying a product, style or idea [one] is purchasing a sign of one's individuality and empowerment" (Gill, 2008a: 437). Gill (2008a: 437) contends that this shift from objectification to sexual subjectification is framed in advertising through a "discourse of playfulness, freedom, and above all, choice." In this discourse female consumers are presented as "not seeking men's approval but as pleasing themselves, and, in so doing, they just happen to win

men's admiration" (Gill, 2008a: 437). Through the juxtaposition of "sexualized representations of women's bodies with written or verbal texts that purport to speak of women's new sexual agency and power" (Gill, 2008a: 438) a new postfeminist sensibility and subjectivity is produced. Gill (2008a: 438) notes that any serious critique must contend with the misappropriation of feminist rhetoric masked in neoliberal and postfeminist discourses, and assess how their deployment in adverts "may act as an alibi for visual representation which – without such playful slogans – might attract considerably more criticism."

This post-feminist shift in advertising rhetoric highlighted in Gill's analysis was evident throughout the 10 websites in my sample, as they all stressed to varying degrees discourses of women's individualism and independence in choosing FGCS procedures, as well as women's need and desire for self-improvement. The websites resoundingly emphasized that FGCS was first and foremost about enhancing women's sexual gratification and satisfaction, while their male partner's sexual pleasure was typically framed as a secondary consideration or a shared benefit of the procedure. Subsequently, the postfeminist notion of 'doing it for me' or 'pleasing oneself' was best captured in two patient testimonials from the Allan Centre for Women. First, through Sarah's testimonial, the clinic attempts to debunk the assumption that many women undergoing FGCS procedures are 'pressured by' or 'doing it for' their male partners:

Dr Bruce Allan says women who come see him for Laser Vaginal Rejuvenation™ are coming for their own reasons, not because their partners are asking for it. It is all a matter of a woman's self-confidence about herself, and Sarah confirms this. "My boyfriend has never said he feels our sex together has improved because I'm tighter - only my self confidence has improved our sex" (Allan Centre for Women).

In Melanie's testimonial about her experience with Laser Vaginal Rejuvenation™, her story begins by stating that, "After having three children, Melanie felt her vaginal opening was too large and she was very embarrassed by it. Although her husband said it was just fine, she felt things looked different and felt "looser" when making love" (Allan Centre for Women). This patient testimonial emphasizes that Melanie—arguably like many other women—came to this decision on her own. The clinic does allow Melanie to admit that her husband "wasn't too crazy about not having intercourse for 6 weeks,"<sup>54</sup> but her testimony goes on to say that the wait "was definitely worth it!" (Allan Centre for Women). However, it remains unclear whether Melanie was speaking on behalf of both herself and her husband.

I reference these two patient testimonials because they employ a common postfeminist and agentic discourse that was found across the provider websites I examined. In all of these women were represented as undergoing elective cosmetic surgery for their own happiness and well-being, rather than for the benefit of others, particularly their male partners (Fraser, 2009: 106). Provider websites' endorsement of women's agency strengthens and legitimizes surgeons' claims that the practice and industry is ethical. In Fraser's (2009: 107) analysis of women's magazine interviews of female cosmetic surgery recipients, she found that the women felt empowered in undergoing elective cosmetic procedures in spite of the resistance they received from those around them.<sup>55</sup> Therefore, despite Sarah and Melanie's partners' denial that they needed vaginal tightening, the testimonials' suggest that these women's ability to remain

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<sup>54</sup> 6 weeks was the recommended recovery period in which patients from this clinic were advised to abstain from strenuous activity and sex following Laser Vaginal Rejuvenation™.

<sup>55</sup> Kathy Davis (1995) has presented similar findings in her book, *Reshaping the Female Body* (recall the previous discussion in Chapter 3).

steadfast and headstrong in their decisions to undergo the procedure is indicative of their applaudable internal motivation and their achievement of self-actualization. According to Fraser (2009: 107), “Cosmetic surgery becomes a means of asserting a new independence and strength of character...[and] the value of undergoing cosmetic surgery is explicitly linked to the sense that such surgery must be for oneself alone, and not to please others.” This sentiment is clearly invoked by both the surgeons offering FGCS procedures and by the very women, like Sarah and Melanie, who ‘choose’ to undergo them. Thus, the celebrated agentic discourses of FGCS patient testimonials encourage clients to enact postfeminist subjectivities because it legitimizes FGCS and helps to undermine criticisms that FGCS is an exploitative and unethical practice that preys on women’s genital insecurities.

I highlight these postfeminist and neoliberal discourses of empowerment, choice, and individualism that structure FGCS provider websites because contemporary media culture’s construction of the new postfeminist figure and feminine subjectivity has significant repercussions for women. According to Gill (2008a: 442), this postfeminist sensibility is more complex than a simple backlash against feminism as it interlocks both feminist and antifeminist discourses. Contemporary feminine subjectivity becomes pernicious as it entangles ideas of autonomy, choice and self-improvement alongside notions of “surveillance, discipline and the vilification of those who make the ‘wrong’ choices” (Gill, 2008a: 442). For Gill (2008a: 443), what is most troubling is not just that women are “governed, disciplined or regulated in ever more intimate ways,” but rather that “notions of choice, agency, and autonomy have become central to that regulatory project;” thus making it more challenging for feminist scholars to articulate the subtle



methods deployed to guard and uphold gender boundaries (Negrin, 2002: 30). The existence of this new postfeminist figure in advertising coincides with the intensification of the media's obsessive and punitive regulation and scrutiny of women's bodies in which no 'transgression' or part of the body is seemingly too small or removed from the public eye and the woman in turn "subjected to an excoriating attack" (Gill, 2008a: 441). I suggest the FGCS industry best exemplifies this newly heightened level of bodily scrutiny, as it subjects women's most 'intimate,' 'hidden,' and 'private' of body parts (both external and internal surfaces) to 'unrealistic' aesthetic standards, evaluations and functional requirements. However, the discourse of freedom, choice and playfulness disguises this process and thus renders such practices as FGCS "knowable through discourses of "pleasing oneself" or "feeling good about oneself"' (Gill, 2008a: 441). Through this neoliberal version of femininity, FGCS is framed as a way of pampering and indulging oneself. The procedures are also presented as freely chosen regardless of how painful they may be—a theme I will address in my final section on the psychological benefits FGCS procedures are purported to produce, following my discussion of FGCS as being patient driven (Gill, 2008a: 441).

### **FGCS Framed as 'Patient Driven'**

In Braun's (2009b: 240) extensive research on FGCS, she found that surgeons emphasize female 'choice' and 'agency,' in order to depict the industry as patient driven. Hence, cosmetic surgeons performing FGCS argue that they are not creating demand but rather responding to it as women have become increasingly distressed over their genital sexual function, due to an assortment of heightened expectations surrounding sexual pleasure, orgasmic abilities, and G-spot responsiveness (Tiefer, 2008: 467). This

discourse of patient care also organizes Canadian FGCS provider websites. For example, the Meridia Medical Group states, “we want women to feel validated and heard” suggesting their patients’ aesthetic and functional genital concerns may have been previously ignored or downplayed by other gynaecological practitioners. This idea that women’s sexual and genital distress is not being heard is evident on The First Glance’s site:

Women come to us because they want knowledge, choice, and alternatives. Women want their gynecologist to listen to them and provide viable solutions. Women throughout this nation and the world have told us that Kegels do not work-but no one is listening. Women who have had children want a solution to rejuvenate the vagina and achieve the best sexual experience possible. For women with no children, solutions are available through design modification to accomplish their desires.

The First Glance aesthetic clinic goes on to proclaim that women have been the main proponents behind the development of FGCS procedures—in particular Laser Vaginal Rejuvenation® (LVR®):

The LVR® program was developed by listening and caring about the needs of women in this area of sexual gratification... Women of the world inspired all of the surgical designs. For this, we as well as present and future patients thank the “true pioneers” and inspirational forces that made Laser Vaginal Rejuvenation® a reality... WOMEN.

By emphasizing women’s involvement in the medicalization of female genital appearance and function, FGCS surgeons dispel harsh criticisms by the media, medical regulatory bodies and feminists that they are engaged in an oppressive, scientifically unfounded and misogynistic practice that perpetuates the subordination of women by exploiting and profiting from women’s genital insecurities.

The Canadian FGCS provider websites consistently appropriate feminist rhetoric through postfeminist and neoliberal discourses of choice, empowerment and agency. In

Moran and Lee's (2013) analysis of four Australian FGCS provider websites, they suggest that this rhetoric is used to justify FGCS procedures. Although the use of feminist rhetoric was not as overt as some of the other discourses all the clinics emphasized women's right to (heterosexual/heteronormative) sexual pleasure. Further, they relied heavily on concepts of choice, individualism, desire, agency, empowerment, as well as bodily transformation, liberation, and freedom, which obscure the beauty ideology that fuels demand for these procedures (Whitcomb, 2010: 32). The appropriation of feminist rhetoric or more aptly, 'pseudo-feminism' on FGCS provider websites is noteworthy as it is being used to promote these procedures as empowering and sexually liberating, help induce sales, reassure potential female patients/clients, and offset criticism of the FGCS and the cosmetic surgery industry (Braun, 2009b; Whitcomb, 2010: 31).

The Canadian sites also speak to the customization of FGCS procedures and the surgeons' ability to address each individual woman's needs and desires. Further, the sites attempt to distinguish themselves from other gynaecological practices and plastic surgery clinics by indicating they seek to "empower women by providing choice, knowledge and health alternatives" (False Creek) and stress that the decision to undergo a FGCS procedure is, "a choice only you can make for yourself" (The Allan Centre for Women). The Meridia Medical Group indicates that the clinic's medical practice is grounded in the 'Feminine Ethics of Care' Framework. According to Meridia Medical, this guiding medical philosophy takes a holistic approach to individuals' healthcare needs and aims to empower patients to understand and fully participate in their care. This suggests the clinic is attempting to redress the power imbalances that exist between medical practitioners and their patients. Through this framework, the clinic stresses that, "You make the final

decisions” (Meridia Medical). For one of their patients, this meant she was able to finally free herself from the secret shame and embarrassment she felt as a result of her ‘thick’ and ‘large’ labia minora, (shown in Appendix A under Meridia Medical Group – labiaplasty patient 12). She recounts this transformation:

It amazes me still that such a secret shame I held onto for so long has finally been acknowledged and dealt with, I feel so liberated. It’s an awesome feeling and I just wanted to make you aware that having this surgery has lifted a weight off my shoulders that I have had for too many years to count...

Here FGCS surgeons rely on neoliberal discourses to justify FGCS procedures, because “neoliberalism removes the language required to locate conformity to narrowly defined beauty standards within a wider postfeminist context” (Moran & Lee, 2013: 16). In other words, by framing women’s desires and decisions to undergo FGCS as a matter of personal ‘choice’, individual ‘freedom’ and ‘autonomy’—as cosmetic surgeons have done before—FGCS surgeons position these procedures as an authentic and genuine expression of women’s individuality, as well as an act of female empowerment and liberation, which grants legitimacy to the practice (Braun, 2009b: 240; Moran & Lee, 2013: 16; Rodrigues, 2012: 784). In contrast, feminist analysis of these discourses suggests that surgeons are attempting to evade criticisms that their procedures—and sexual enhancement technologies in general—are taking advantage of women’s perception that they are somehow deficient (Tiefer, 2008: 471).

Ultimately, the positions endorsed by Canadian FGCS provider websites are similar to that of other cosmetic surgeons, and more importantly reaffirm Gill’s (2008b) critique that contemporary women’s agentic capabilities are restrictively confined to the management of their physical appearances and consumerism. I suggest that the surgeons’ postfeminist celebration of women’s individualism and their perceived ‘unconstrained’

autonomy does not serve feminist or cultural understandings of women's engagement in cosmetic surgery well. Indeed, as Gill (2008b: 44) argues these discourses:

...cannot account for why the look that young women seek to achieve is so similar: if it were the outcome of everyone's individual, idiosyncratic preferences, surely there would be greater diversity, rather than growing homogeneity organized around a slim yet curvaceous, toned, hairless, young body. Moreover, the emphasis upon choice simply sidesteps and avoids all the important but difficult questions about how socially constructed ideals of beauty are internalized and made our own.

Gill's critique reiterates the need to contextualize women's decisions and desires to engage in beauty practices, such as cosmetic surgery, rather than simply taking their reasons at face value and dismissing the wider societal systems which shape women's unequal social position. Feminist scholars would do well to heed Gill's (2007: 72) call to "complicate our understandings of choice and agency," because in doing so we will be able to critique the ideological work performed by neoliberal and postfeminist discourses that FGCS surgeons invoke in their defense of this controversial practice (Moran & Lee, 2013: 16).

Gillespie's (1996) work also contributes to the critical assessment of the wider social consequences that the medicalization of appearance has had on different women. Most importantly, in her discussion of cosmetic surgery, she (1996: 78) recognizes that, "Women may be seen as collaborating with the normalizing practices that serve to maintain their subordination." This is because through women and girls' engagement in beauty practices, such as cosmetic surgery, they contribute to oppressive social institutions and structures by reproducing and thus reinforcing patriarchal ideologies that naturalize and normalize limited and restrictive models of femininity for all women (Gillespie, 1996: 69, 82; Stuart & Donaghue, 2011: 100). However, according to

Gillespie (1996: 70), individual women who chose to participate in the medicalization of appearance through cosmetic surgery may be “acting rationally by investing in their bodies and increasing their status and social power in a society that values women in specific and limited ways,” which arguably may be empowering and liberating at the individual level. Despite the benefits such participation may bestow on the individual woman (Parker, 2010), *The New View Campaign* notes that as more women engage in the oppressive cultural beauty practices like FGCS, it “inevitably adds weight to an already oppressive environment” (Tiefer, 2008: 474). Thus, the growth of this industry further rigidifies the standards and erodes the possibility of resistance for the next woman and the next generation (Tiefer, 2008: 474). Feminist scholar Llewellyn Negrin (2002: 26) argues that:

What may be a solution for a particular individual in certain circumstances may not be so at the social level, insofar as it still leaves intact the structures of gender inequality that present women with few options but to have plastic surgery (quoted in Tiefer, 2008: 474).

The practice of cosmetic surgery has far-reaching consequences that extend beyond those who actually undergo elective cosmetic procedures (Braun, 2005b: 345; Fraser, 2003). Blum (2003: 44) and Braun (2005b: 345) suggest that in a ‘postsurgical culture’ where surgical intervention of one’s appearance becomes affordable for the vast majority of people, the bodies of all women [and increasingly those of men] are compromised regardless of one’s personal decision to either undergo or refuse cosmetic surgery. More simply, according to Braun (2005b: 345), “we are [all] inevitably in a relationship to surgery regardless of whether we actually become surgical.” Therefore, as external pressures accumulate, it is notably ‘easier’ for individuals to change themselves in order

to fit societal expectations and norms, than it is for individuals to change society (Braun, 2005a: 419).

### **FGCS as Psychological Transformation – ‘Psychotherapy with a Scalpel’?**

When it comes to the ‘benefits’ that FGCS procedures have for ‘treating’ women’s genital appearance concerns and/or their dissatisfaction over vaginal laxity/‘looseness,’ all of the Canadian FGCS provider websites are organized by discourses of psychological and sexual transformation to help sell and promote these procedures. Braun (2005a: 411) similarly found that, “although physical pain was often discussed, the *psychological* response to genital morphology was frequently highlighted as the crux of the problem which ‘hampered’ or ‘ruined’ [women’s] sex life.” In this context, FGCS procedures are promoted as reasonable and rational operations to alleviate women’s emotional distress (Braun, 2009a: 140). Psychological and sexual transformation discourses frame these surgeries as ‘psychotherapy with a scalpel’ (Braun, 2005a: 416; Kennedy, 2009: 223). Braun (2005a: 416) suggests that here, the psychological is framed as a primary reason why surgery is essential, while the presumed transformation the patient experiences is promoted to explain why surgical interventions are successful. Braun (2005a: 416) goes on to explain that:

The mind [is] implicitly constructed as impervious to change *without* surgery, but then as changing once surgical alteration [is] completed. Cosmetic surgery is thus about changing the body to change the mind and becomes the ‘best or most effective means of attaining satisfaction’ about bodily distress...the body is situated as ontologically prior to the mind, but the mind is located as the crucial variable, in sexual pleasure terms.

Hence, FGCS procedures are discursively constructed as providing embodied solutions to psychological genital concerns (Braun & Tiefer, 2010: 2).

The emphasis given to the psychological and transformative benefits that FGCS procedures can potentially provide to patients is unsurprising, especially when considering the medical community's tendency to inflate the language of pain to include such psychological concepts as embarrassment, self-consciousness, and shame (Frank, 2003, cited in Braun, 2005a: 411). All websites draw on this psychological language. For example, they emphasize that enlarged labia or vaginal laxity can be a great source of shame, embarrassment, and anxiety for many women, causing women be self-consciousness, which can result in a loss of sexual confidence and/or a lack of sexual enjoyment (for both partners), and can lead to the avoidance of intimate relationships. However, both labiaplasty and vaginoplasty are celebrated as easy surgical solutions to these concerns, as patients are often reported as experiencing improvements to their self-confidence, self-esteem, emotional comfort with sex, and overall wellbeing.

There continues to be a debate in the field of critical studies on cosmetic surgery over whether empirical evidence indicates that elective cosmetic surgery has positive emotional health implications that enhance psychological and/or relationship wellbeing (Heyes, 2007a; Polonijo & Carpiano, 2008). Despite this, the industry has been historically dependent on claims that cosmetic surgery results in psychological benefits for patients (Heyes, 2007a). According to Heyes (2007a: 63), this tenet has been frequently taken for granted as 'common sense' and remains conceptually central to the cosmetic surgery industry's survival and ability to flourish. However, Lloyd et al. (2005: 645) contend that, "there is currently no evidence that [FGCS] procedures *per se* enhance psychological or relationship wellbeing for any female population...rather, evidence-based methods for alleviating psychological or relationship distress in the general



population do not involve surgery.” Again, Liao et al. (2012: 5) reassert this claim that psychological complaints concerning women’s genital anxiety, self-consciousness, and lack of sexual-esteem are most effectively addressed by psychological [non-surgical] interventions. In Cressida Heyes’ (2007a: 63) article, *Normalisation and the psychic life of cosmetic surgery*, she relays the findings of Ted Grossbart and David Sarwer’s 1999 literature review on the topic, as they conclude, “the overall (positive) psycho-social impact of cosmetic surgery has yet to be demonstrated by a methodologically convincing study.” Further, Heyes (2007a) highlights the ambivalence of the existing literature on the psycho-social impacts of cosmetic surgery by including Sarwer and Canice Crerand’s 2004 observations that “it likely remains premature to confidently conclude that cosmetic medical treatments lead to positive psychological benefits in the majority of patients” (quoted in Heyes, 2007a: 63). However, Lloyd et al. (2005: 645) advise that as long as surgery continues to remain an option, “even meticulous consultation skills may not alter women’s desire for risky cosmetic procedures.”

In spite of the lack of conclusive empirical evidence, the Canadian FGCS provider websites’ surgeon and patient testimonials do speak to psychological improvements in terms of boosting a women’s self-image, self-esteem and sex life after surgery. Dr. Martin Jugenburg of *Toronto Cosmetic Surgery Institute* has gone on record in two *National Post* articles to dispute claims that there are no proven benefits to FGCS operations by stating most of his patients have reported the contrary. In Tom Blackwell’s (2014) *National Post* article, *Wave of popularity of cosmetic surgery on female genitalia worries some critics*, Dr. Jugenburg admits to performing ‘quite a few’ labial reduction procedures every week and emphasizes that feelings of genital anxiety and insecurity can

be sexually inhibiting for many women: “So often, someone will tell me ‘My partner has never seen me in the light, it’s always in the dark, I’m so ashamed of how I look down there’...They want to be more comfortable with their partners.” In a subsequent article by the *National Post*, Dr. Jungenburg counters the claim that there is hardly any long-term studies and data on FGCS procedures because these procedures are relatively new by acknowledging that there have been studies conducted in both Europe and the United States that attest to these procedures safety and low complication rates (studies were not cited in the article - Kirkey, 2014). He went on to add that his patients tend to be “very happy and very satisfied” with the results of the FGCS procedures he performs (Kirkey, 2014). However, in this article he’s hesitant to endorse the sexual and psychological transformations that these surgeries have been reported to provide:

You need to be cautious, you need to counsel your patients properly so they’re fully aware of what they’re doing and they need to understand that this is not necessarily a ‘great sex’ surgery. I explain to all my patients that this is not a great sex surgery. This is a cosmetic procedure that changes the appearance and the feelings in the vaginal area...Sex is part physical and part emotional. We only deal with the physical factor (Dr. Jungenberg quoted in Kirkey, 2014).

However, after assessing the claims found on the *Toronto Cosmetic Surgery Institute’s* website, it appears that Dr. Jungenberg is claiming that surgery can address the emotional or psychological aspects of women’s sex lives. In relation to labiaplasty, the website provides this description, “For many women who dislike the appearance of their labia, or who experience discomfort because of excessive labia tissue, this procedure can *improve the way they feel about their bodies*, their physical comfort, and *emotional comfort with sex*” (Toronto Cosmetic Surgery Institute – emphasis added). Additionally, the website states:

Undergoing labiaplasty surgery can have extremely positive effects for patients. Our patients have experienced *improved self-confidence* thanks to the youthful appearance of their labia, increased physical comfort because of excess labia tissue being removed, and improved sexual experiences because of *reduced anxiety* about their labia appearance. (Toronto Cosmetic Surgery Institute – emphasis added).

Thus, although, Dr. Jugenberg stresses in the *National Post* interview that his clinic only deals with the physical, the above extracts suggests otherwise. Additionally, the website states that, “If you are *insecure* about the appearance of your labia, or experience pain because of the size or shape of your labia, you could well be a good candidate for labiaplasty. For such patients, this procedure can *boost wellbeing and confidence*” (emphasis added, Toronto Cosmetic Surgery Institute). The quote does address physical pain and discomfort as potential reasons for undergoing labiaplasty, but the use of the word ‘or’ indicates that aesthetic insecurities are a legitimate enough reason on their own for one to be considered for a labial reduction. According to Liao et al. (2010: 23), “dissatisfaction with appearance is, by its very nature, a psychological phenomenon.” Further, Ivo Pitanguy, the acclaimed father of cosmetic surgery in Brazil, stresses that, “there is always a therapeutic objective with cosmetic surgery, which is ‘not the body but the mind’ because ‘patients notoriously do not have an objective body image’” (Berer, 2010: 9). I argue that Dr. Jugenberg and his clinic are ‘treating’ more than just the ‘physical’ or ‘material’ aspects of women’s genitalia, as the website is clearly promoting the ‘potential’ psychological and sexual transformative benefits of FGCS procedures.

Similarly, Dr. Bruce Allan of Calgary’s *Allan Centre for Women*, states in Blackwell’s (2014) article he “never promises he will transform their (his patients) lives, in bed or out.” However, his clinic’s website appears to be promising the very thing he publicly denies. Patient testimonials provided on the *Allan Centre for Women* website

address sexual and psychological transformation. Kelly's story boasts that, "Laser Labioplasty changed the way she felt about herself" and is followed by a detailed account of how transformational the entire process had been (Allan Centre for Women):

'I can't say enough about how having a labioplasty has *boosted my confidence!*' says Kelly, who admits that although nobody had ever told her that her vagina was unattractive, that's how she felt. Post procedure, Kelly says she really likes the way she looks and that she is much *more comfortable being naked* and is *able to enjoy sex more*. (emphasis added - The Allan Centre for Women).

Sarah's testimonial is even more direct with the following tagline: "Laser Vaginal Rejuvenation changed her sex life and self-esteem" (Allan Centre for Women). In Sarah's patient account there were several psychologically based indicators given for pursuing LVR, including boosting her self-esteem and confidence. Below is a sample of the clinic's coverage of Sarah's patient experience:

For years, Sarah had very *low self-esteem* when it came to her body, specifically her vagina...For two years, Sarah *abstained from sex* because she felt her vagina was too loose, and she was *self-conscious* about the aesthetics of her vagina.

When the man she wanted to have a life-time commitment with entered her life, Sarah felt motivated to seek solutions to her physical problems, not knowing if there was anything that could actually be done. A search engine search on terms such as "vaginal tightening methods" and "can a loose vagina be tightened" and "what is the cause of a swollen labia" directed her to the Allan Centre and Dr Bruce Allan. *What happened next Sarah says literally changed her life.*

*"Laser Vaginal Rejuvenation™ has improved my sex life and self esteem. I'm happier and more self confident.* Because of this, my boyfriend is a lot happier as well. I feel tighter, so I feel more pleasure when I'm having sex" (emphasis added – Allan Centre for Women).

I highlight Sarah's testimonial as additional evidence of the contradictions between Dr.

Allan's public statement made in the *National Post* and what he actually appears to promote though his website:

'Wondering whether there are *vaginal tightening methods that can improve sexual love life*, or wondering about aesthetic vaginal enhancements, or feeling plagued by a large labia that swells simply from wearing pants or having sex, isn't exactly

a topic of conversation you have with friends or loved ones,’ adds Dr Allan. ‘When I tell women that through a simple procedure *I can solve these problems*, I’ve literally had women break down and cry in my office from the sense of relief they feel’ (Allan Centre for Women).

While Dr. Allan neither denies nor fully confirms whether vaginal tightening methods ‘can improve [one’s] sexual love life,’ he nevertheless confidently states that he *can solve* both physical and psychological problems associated with having large labia or a ‘relaxed’ vagina—with the emphasis being on the need for a surgical solution. Although, he does not explicitly guarantee or promise positive outcomes, the statement strongly suggests patients’ genital concerns will be resolved by undergoing FGCS procedures. Koning et al. (2009: 70) suggest that the active promotion of FGCS procedures combined with FGCS provider websites’ presentation of patients’ positive and transformative experiences has “possibly encouraged women to feel that not undergoing labial reduction is a missed ‘opportunity.’”

The websites I examine present numerous patient accounts regarding the ‘life-changing’ impacts FGCS procedures for one’s self-esteem and self-confidence, and the resultant sexual benefits. I argue that clinics marketing of these ‘potential’ transformative sexual and psychological benefits reinforces the belief that aesthetic genital distress can *only* be treated through surgery, which impedes the development of alternative solutions (Liao & Creighton, 2007: 1091). Liao and Creighton (2007: 1092) note that, “the surgical fix [can be] so compelling that it can be difficult to explore the psychological basis for surgery beforehand, or even afterwards.” Further, Liao and Creighton (2007: 1091) suggest that the drive for the ‘surgical fix’ along with a societal indifference regarding alternative options prevents a meaningful discussion concerning the benefits and harms of surgical solutions. The ‘surgical fix’ to treat psychologically

rooted concerns regarding one's appearance has been a prominent discourse used in cosmetic surgery endorsements and advertisements. Polonijo and Carpiano's (2008: 468) find that:

In the cases where patients had negative indicators of emotional health before surgery, their emotional state was represented as being unchangeable without surgical intervention. Once intervention had been performed on these patients, however, the results were both a physical and emotional improvement. Consequently, cosmetic surgery [was] presented as a means of reshaping the body to alter the mind. Poor indicators of emotional health were framed as a reason why cosmetic surgery was necessary, and the perceived emotional health benefits of cosmetic surgery are offered as justification of surgery's success.

Tiefer (2008: 469) echoes a similar sentiment in reference to the sexopharmaceutical industry's focus on 'quick fixes' and 'instant success', which suggest that "[one must] change the body to change the (sex) life." In this context, I understand the appeal of the 'surgical fix' to solve one's psychologically based genital anxieties, as it involves minimal personal responsibility, effort, and/or commitment on behalf of the patient, which is a rational decision to make in a society that has grown accustomed to 'instant gratification' and embraces 'quick fixes' (Lloyd et al., 2005: 645).

Overall, the practice of FGCS may enable certain women to experience more uninhibited sexual expression due to the psychological effect these procedures can have, as the patient testimonials on the FGCS provider websites attest (Rodrigues, 2012: 790). However, patient testimonials and the psychological benefits they purport for cosmetic surgery should never be taken in place of empirically validated longitudinal studies, as patient accounts remain highly context-relative and specific (Heyes, 2007a: 63). Heyes (2007a: 63) stresses that patient accounts cannot be generalizable to the wider population, as "patients have different expectations and motivations, undergo vastly different procedures, and have different outcomes." Ultimately, I suggest there should be a more

concerted effort by gynecologists—many of these surgeons have this training—to educate women [and men] that “healthy vulvas come in all shapes, sizes and colours, [and] that all vulval appearances are compatible with psychological and sexual wellness,” in order to help foster a more realistic genital image for women (Liao et al., 2012: 5). Despite the presumption that cosmetic surgery makes people feel better about themselves, it undeniably contributes to discourses that make individuals, particularly women, feel worse about themselves as well (Blum, 2003: 56).

## **Chapter 7 – Conclusion**

### **Introduction**

This chapter reiterates my findings regarding the discursive legitimization of female genital cosmetic surgery on Canadian provider websites, and highlights potential future directions for feminist research on FGCS overall. I conclude by outlining recommendations for combating female genital shame in the hope that these efforts could offset demand for FGCS procedures. In addition, I critique the adequacy of reforms suggested by professional medical associations in their efforts to ensure the safety and well-being of the women who choose to undergo FGCS procedures.

My analysis of Canadian FGCS provider websites indicates that the discourses used to normalize genital cosmetic surgery are deeply troubling insofar as they tend to infantilize women's sexuality, stigmatize sexually mature women's bodies and, as McNamara (2006: 14) argues, encourage women to be engaged in their own subjection. My analysis contributes to the larger body of feminist literature on FGCS through charting how Canadian provider websites exercise discourses that overwhelmingly pathologize genital diversity; promote heteronormative models of femininity; and employ neoliberal and post-feminist rhetorics of individual choice and empowerment to promote services that, according to the Society of Obstetricians and Gynaecologists of Canada (2013), should not be performed as they have no medical origin. Indeed, discourses that represent genital surgery as a legitimate route to psychological transformation legitimize the FGCS industry and frame FGCS as the only viable solution to alleviate genital and sexual distress – despite the very significant medical risks to women who undergo these procedures. Undoubtedly, feminist scholars need to act as 'cultural critics' (Braun,



2005a), when FGCS surgeons are allowed to profit from ethically dubious practices that promote untested surgical benefits and reinforce both suspect norms of appearance and heteronormative sexual scripts (Braun, 2005a; Little, 1998; Tiefer, 2008). Ultimately, the advertising discourses employed on Canadian FGCS provider websites have real material and political impacts for women's bodies and sexuality, which links the practice of FGCS to larger political and feminist debates regarding women's embodiment. My analysis provides the first contextual and empirical evidence regarding the operation of restrictive heteronormative Western beauty norms on Canadian FGCS provider websites. My work also collaboratively builds upon and supports contemporary feminist scholarship, which emphasizes the continuing significance of political debates concerning Western beauty norms and their potentially harmful impacts on the representation of women's sexuality and bodies.

### **Opportunities for Future Feminist Research on FGCS**

My analysis was restricted to the discourses on Canadian FGCS provider websites, and focused exclusively on labiaplasty and vaginoplasty. Therefore, future research could assess the marketing tactics used to sell other FGCS procedures, in particular, hymenoplasty. Future FGCS research could also consider how these procedures are depicted in television programming (i.e., news coverage, talk shows, reality/makeover shows) and other media sources (i.e., editorial coverage in magazines, online blogs, etc.). Although my research documents the various discourses directed to women via Canadian FGCS provider websites, my analysis is unable to account for how women process and/or interpret these messages (Polonijo & Carpiano, 2008). Therefore, FGCS research would benefit from qualitative interviews with women who have

considered these procedures, as well as women who have undergone FGCS procedures in Canada. I am also interested to see future research on FGCS that might assess the effectiveness of sex positive education efforts to alleviate women's feelings of genital anxiety and shame, as well as a critical examination of how women resist cultural pressures to have a 'clean slit' (Braun, 2005a).

## **Recommendations**

Multiagency initiatives are required to help women and girls overcome feelings of genital anxiety (Liao & Creighton, 2007). Feminist activism, information from health agencies, and educational and regulatory bodies, as well as the media could all contribute to developing innovative strategies to challenge representations of 'pudendal disgust' and to promoting women's sexual-esteem and reproductive health (Liao & Creighton, 2007: 1092). Contemporary misogynistic representations of the vagina need to be contested because "these representations could be seen as encapsulating (Western) society's attitudes towards, and responses to, the vagina, as well as attitudes to women more broadly" (Braun & Wilkinson, 2001: 25). Hence, this final section critiques professional medical associations' calls for reform and greater accountability within the FGCS industry and medical community at large. I conclude by emphasizing the need for feminist activist initiatives centered on combating the contemporary depictions of 'pudendal disgust' as they exacerbate female genital anxieties and fuel demand for FGCS procedures.

Although the Society of Obstetricians and Gynaecologists of Canada (SOGC) (2013) and the Royal College of Obstetricians and Gynaecologists (RCOG) (2013) both released several recommendations concerning the medical ethics of FGCS, both are only

professional associations and thus lack the necessary enforcement and oversight in their respective countries to have any real impact on these controversial procedures and/or in deterring physicians from continuing to offer them. More importantly, their recommendations are tailored to their respective members – the medical community – and as a result concern best practices.

The SOGC (2013) and RCOG (2013) emphasized the crucial role that healthcare providers, especially obstetricians and gynaecologists play in educating women about their genital anatomy and the normal variations of vulval morphology. The RCOG (2013: 7) stress that, “Education, support and advice should be at the heart of clinical practice, with a sympathetic appreciation of female body insecurities.” However, the quality of sexual health training provided in medical schools needs to improve, if physicians are to treat their patients who experience genital distress with the sensitivity and respect they deserve. According to Howarth et al. (2010: 78), “Sexual health training only constitutes 3-10 hours in over 60% of North American medical schools surveyed, and there is some evidence that medical students feel their training in sexual health is inadequate.” Therefore, the lack of curriculum devoted to sexual health training for physicians impedes non-specialist medical professionals’ ability to provide adequate care and accurate information to women concerned about their genital appearance, as these physicians may be unable “to communicate what constitutes the average range of female genital variation and...how ideas about ‘normality’ arise” (Howarth et al., 2010: 78). The SOGC’s (2013) recommendations reaffirm the need for physicians to be educated about female genital distress and FGCS procedures. In the SOGC’s (2013: e2) recommendations, they explicitly state that informed consent for women undergoing

FGCS should include counseling and a discussion of normal genital variation; the physiological changes over one's lifespan; the unintended consequences cosmetic surgery may have to the genital area and sexual sensitivity; the lack of evidence regarding outcomes; and the lack of data on the impact of subsequent changes during pregnancy or menopause.

Expanding the criteria for informed consent to include the topics outlined above by the SOGC (2013) is an important step to ensuring women are made fully aware of the risks FGCS may pose to their sexual function and health. However, Bramwell et al. (2007: 1497) claim that, "Showing pictures which demonstrate natural variation in [vulva] appearance may...not address [women's] concerns" because "women requesting labial reduction [who] describe their genitalia as 'abnormal' may not mean that it falls outside the normal range, but rather that it is in some sense *stigmatizing*" (emphasis added). Further, Liao and Creighton (2007: 1092) argue that:

An increased desire for the longed for fix could subsequently compromise the patient's capacity to process information on risks and limitations about their desired intervention. Even with psychological expertise, the surgical context is unlikely to encourage women and girls to acknowledge and explore their struggles to develop a range of solutions.

As there may be limits to what conversations are possible in a medical context, I recommend expanding feminist activist and consciousness-raising efforts focused on challenging the negative socio-cultural representations of the vagina, as well as the invisibility of women's genital diversity. These efforts could provide a broader range of alternative representations and enhance women's sexual and reproductive well-being and combat demand for FGCS procedures. Braun and Wilkinson (2001: 27) argue that, "Breaking the taboo of secrecy and shame that often surrounds the vagina by talking

(seriously) about it, and by thinking critically about, and challenging, negative representations of the vagina, is crucial to this process, and to developing better models of practice.” Ultimately, positive sex education and the dissemination of alternative media images that represent a diverse range of sexually mature female genitalia is key to combatting misogynistic ideals about women’s genitalia that fuel women’s distress about their genital appearance and lead some women to seek out FGCS procedures (Braun, 2012; Schick et al., 2011).

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## Appendix A – Labiaplasty Before & After Gallery

**Clinic 360** 1131A Leslie Street, Unit 300 Toronto, Ontario, Canada M3C 3L8



Patient 1 – Labiaplasty Before & After Photo



Patient 2 – Labiaplasty Before & After Photo



Patient 3 – Labiaplasty Before & After Photo

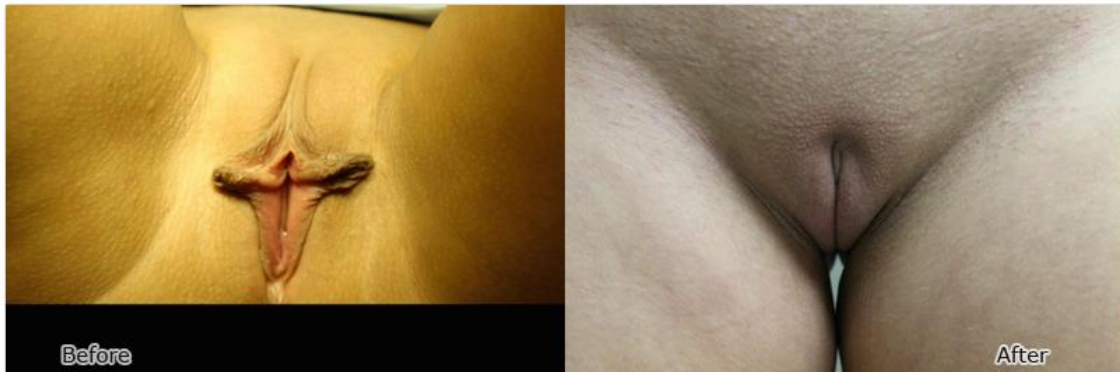


Patient 4 – Labiaplasty Before & After

## The First Glance Aesthetic Clinic and Surgery Centre

1851 Grant Avenue Winnipeg, Manitoba Canada R3N 1Z2

Labiaplasty Patient # 1 at The First Glance(1)



Patient 1 – Labiaplasty Before & After

Labiaplasty Patient # 2 at The First Glance(1)



Patient 2 – Labiaplasty Before & After (Image 1)

Labiaplasty Patient # 2 at The First Glance(2)



Patient 2 – Labiaplasty Before & After (Image 2)





Patient 3 – Labiaplasty Before & After



Patient 4 – Labiaplasty Before & After

## Toronto Cosmetic Clinic (TCC)

5400 Yonge Street Suite 110, Toronto, ON M2N 5R5 Canada



Our **23 year old** patient was bothered by her **enlarged labia minora**. Using the **Barbie labiaplasty** technique, her above results are **5 months** after the procedure.

Patient 1 – Labiaplasty Before & After



Our **21 year old** patient was bothered by her **enlarged labia minora**. Using the **Barbie labiaplasty** technique, her above results are **6 months** after the procedure.

Patient 2 – Labiaplasty Before & After



Our **26 year old** patient was bothered by the **stretched skin around her clitoris** and her **large labia minora**. Using the **Barbie labiaplasty** technique, her above results are seen **8 months** later.

Patient 3 – Labiaplasty Before & After



Our **35 year old** patient was bothered by her **enlarged labia minora**. Using the **Hybrid labiaplasty** technique, her above results are **4 months** after the procedure.

Patient 4 – Labiaplasty Before & After



Our **31 year old** patient was bothered by the **stretched skin around her clitoris** and her **large labia minora**. Using the **Rim labiaplasty** technique, her above results are seen **6 months** later.

Patient 5 – Labiaplasty Before & After



Our **41 year old** patient was bothered by her **enlarged labia minora** and **labia majora**. Using the **Hybrid labiaplasty** technique, her above results are **6 months** after the procedure.

Patient 6 – Labiaplasty Before & After



## The New Woman™ Canada

1338 West Broadway, Suite 300 Vancouver BC, V6H 1H2

### Patient #1



Before



Before



After 2 Weeks



After 6 Weeks

Patient 1 – Labiaplasty Before & After

## Patient #2



Before



After 2 Weeks



After 6 Weeks

Patient 2 – Labiaplasty Before & After

### Patient #3



Before



After Post-Op



After 2 Weeks



After 6 Weeks

Patient 3 – Labiaplasty Before & After

## Patient #4



Before



After 2 Weeks



After 6 Weeks

Patient 4 – Labiaplasty Before & After

Patient #5



Before



Before



After 2 Weeks



After 6 Weeks

Patient 5 – Labiaplasty Before & After

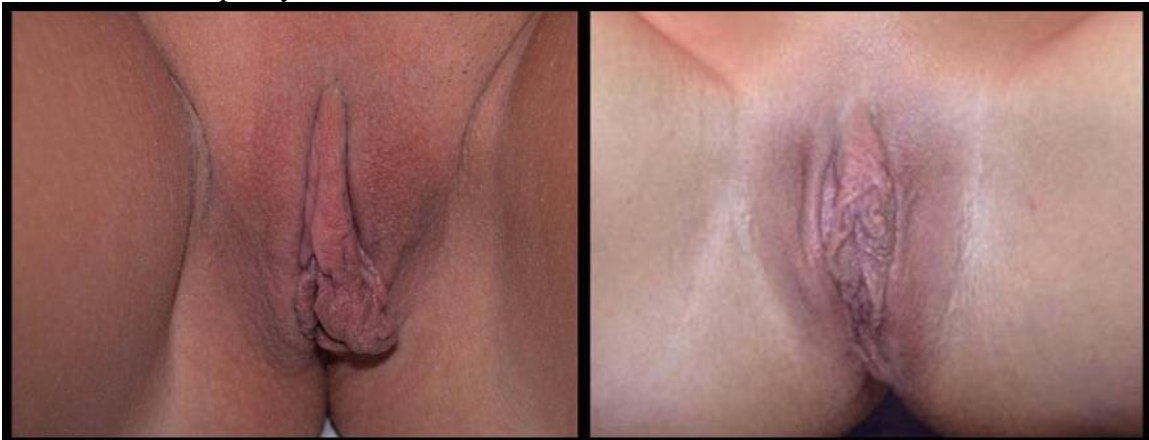




Patient 1 – Labiaplasty Before & After



Patient 2 – Labiaplasty Before & After



Patient 3 – Labiaplasty Before & After



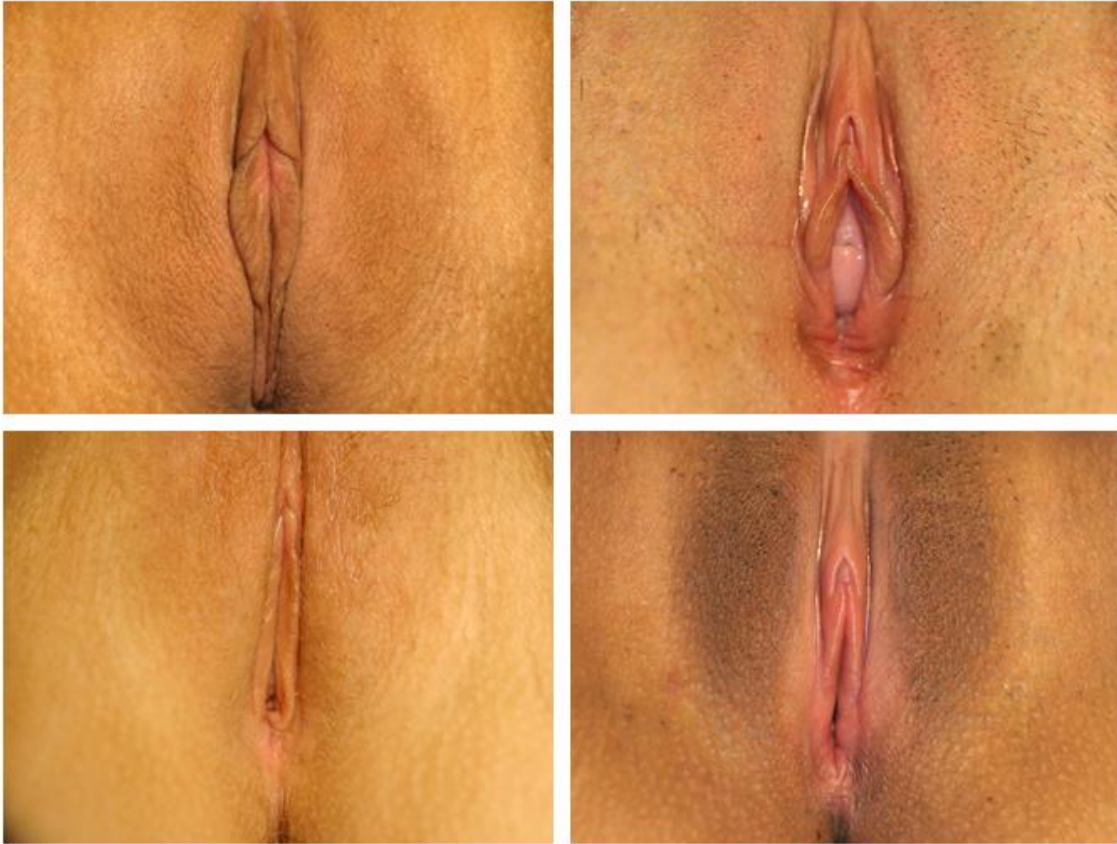
Patient 4 – Labiaplasty Before & After

**Meridia Medical Group**

1881 Yonge Street, Suite 501, Toronto ON. Canada M4S 3C4

**BEFORE AND AFTER**

**NORMAL**



Example of 'Normal' Vulva Appearance at start of Before & After Gallery



**Photographs: Normal Labia**



Example of 'Normal' Vulva Appearance offered at start of smaller Before & After Gallery on website

**PHOTO 1**

The inner labia were wider on the top with irregular borders which the patient found very unattractive. After the surgery, she was ecstatic with the result.



**BEFORE**



**AFTER**

Patient 1 – Labiaplasty Before & After

**PHOTO 2**

This young woman was bothered by the size and shape of her labia.



**BEFORE**



**AFTER**

Patient 2 – Labiaplasty Before & After

**PHOTO 3**

This woman disliked the size and hanging appearance of her labia. She also has extra folds of tissue adjacent to the clitoris which bothered her. She was thrilled with the outcome.



**BEFORE**



**AFTER**

Patient 3 – Labiaplasty Before & After

**PHOTO 4**

This patient was uncomfortable during sport with the size of her labia minora. She experienced discomfort. This dissappeared after the surgery.



BEFORE



AFTER

Patient 4 – Labiaplasty Before & After

**PHOTO 5**

These inner labia were different in shape due to excess tissue on the one side only. This woman was self conscious about this. The surgery was simple and very effective.



BEFORE



AFTER

Patient 5 – Labiaplasty Before & After

**PHOTO 6**

This labia was symmetrically elongated in the upper part of the labia minora, causing a hanging effect. The surgery resulted in smaller, symmetrical and normal appearing labia minora.



BEFORE



AFTER

Patient 6 – Labiaplasty Before & After



**PHOTO 7**

These inner labia were very wide especially on the upper parts. In addition, there was a wide ridge of excess tissue all the way around the bottom which was also removed during the procedure.



**BEFORE**



**AFTER**

**Patient 7 – Labiaplasty Before & After**

**PHOTO 8**

This young lady had extremely wide, long and shaggy labia minora which drooped far down. She was very embarrassed about this and had difficulty during intercourse although her partner never voiced dissatisfaction. The result speaks for itself. She and her partner were very happy with the result.



**BEFORE**



**AFTER**

**Patient 8 – Labiaplasty Before & After**

**PHOTO 9**

These labia were hanging and “shaggy” in appearance causing severe embarrassment. This patient was extremely happy with the result.



**BEFORE**



**AFTER**

**Patient 9 – Labiaplasty Before & After**

**PHOTO 10**

This labia was symmetrically elongated in the upper part of the labia minora, causing a hanging effect. The surgery resulted in smaller, symmetrical and normal appearing labia minora.



**BEFORE**



**AFTER**

**Patient 10 – Labiaplasty Before & After**

**PHOTO 11**

This patient had one side of her labia minora much larger than the other.



**BEFORE**



**AFTER**

**Patient 11 – Labiaplasty Before & After**



**PHOTO 12**

These labia minora were thick and large. This young woman was very embarrassed about the appearance and avoided dating because of this. Afterwards she wrote: "It amazes me still that such a secret shame I held onto for so long has finally been acknowledged and dealt with, I feel so liberated. It's an awesome feeling and I just wanted to make you aware that having this surgery has lifted a weight off my shoulders that I have had for too many years to count..."



**BEFORE**



**AFTER**

**Patient 12 – Labiaplasty Before & After**

**PHOTO 13**

These labia minora were wide and folded. The result shows obvious reduction and symmetry.



**BEFORE**



**AFTER**

**Patient 13 – Labiaplasty Before & After**

PHOTO 14

These labia were catching on underwear especially during exercise. The result solved these problems.



BEFORE



AFTER

Patient 14 – Labiaplasty Before & After

PHOTO 15

Long, folding labia before, symmetrical smaller labia afterwards.



BEFORE



AFTER

Patient 15 – Labiaplasty Before & After

PHOTO 16

This young lady was very self-conscious about the size and shape of her labia. She was ecstatic about the result.



BEFORE



AFTER

Patient 16 – Labiaplasty Before & After

PHOTO 17



BEFORE



AFTER

Patient 17 – Labiaplasty Before & After



## **Appendix B – Feminist Activism & Female Genital Diversity Resources**

### **Valuable Books Depicting Female Genital Diversity:**

1. The Cunt Coloring Book (1989) by Tee Corinne
2. Femalia (1993) by Joani Blank
3. Petals (2003) by Nick Karras
4. I'll Show You Mine (2011) by Wrenna Robertson
5. 101 Vagina (2013) by Philip Werner
6. Vagina Vérité (2013) by Alexandra Jacoby
7. Sex for One: The Joy of Selfloving (1996) by Betty Dodson contains her famous vulva drawings

### **Valuable Art Projects:**

1. The Great Wall of Vagina by Jamie McCartney (British sculptor).  
<http://www.greatwallofvagina.co.uk/home>
2. 'CUNTS and Other Conversations' by Greg Taylor (Australian sculptor)
3. Cunts the movie (film in post-production). <http://cuntsthemovie.com/>
4. American Apparel T-shirt by Canadian artist Petra Collins. The T-shirt depicts a close up drawing of a woman's vulva (with pubic hair) as she is masturbating while menstruating.
5. Cunt Art of 1970s (Hannah Wilke, Judy Chicago, Pink Champagne, Red Flag, Ruth-Eloise Lewis)

### **Online Feminist Female Genital Diversity Resources, Campaigns, and Support Networks:**

1. Large Labia Project  
<http://largelabiaproject.org/>
2. Courageous Cunts  
<http://courageouscunts.wordpress.com/>
3. Pussy Pride Project  
<http://mollysdailykiss.com/pussy-pride-project/>
4. The New View Campaign  
<http://www.newviewcampaign.org/>

### **Non-Visual Books/Plays:**

1. The Vagina Monologues (1996) by Eve Ensler
2. Cunt: A Declaration of Independence (1998) by Inga Muscio